

# Critical Care Physician Coverage

**Critical Care physician coverage:** Physician coverage of the ICU must be available within thirty (30) minutes, with a formal plan in place for emergency. There must be emergency coverage in-house twenty-four (24) hours per day. Supporting documentation must include a signed letter of commitment and proof of physician coverage twenty-four (24) hours a day.

a. **Documentation required:**

- i. Past three (3) months call schedules for critical care coverage and include physician names if initials are used on the call calendar.
- ii. Signed letter of commitment from critical care physician group and Trauma Medical Director
- iii. Policy/guideline for who manages airway emergencies on the floor.

**Evidence:**

- i. Oct – December critical care coverage
- ii. Signed letter of commitment
- iii. Guideline for airway emergencies
  - a. Rapid Response Team Procedure
  - b. Respiratory Therapy Plan for the Provision of Patient Care

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**Abstract**

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# ADHYA

1M / Critical Care





DAY SCHEDULE 7:00 AM TO 5:00 PM														
INDIANA INTERNAL MEDICINE CONSULTA Monday thru Friday														
INTERNAL MEDICINE														
ST. FRANCIS A.M. ROUNDING														
2019	ED/CDU	Heart Center	3W Post Surgery	SW	SW	MFCU	SW/FLEX	SP/AM PM-OP	CHIEF/FLX	FAM/SPM After 10PM Call Hospitalist Page	GWH SP/GWM After 10PM Call Hospitalist Page	CONSULTS	ICU NP/PA 11:00 A.M. TO 9:00 P.M.	SHO/DEW HELD/PM
11-Nov	Naum	Aras/Ponaguet	Will	Shah/Ayoubi	Bullock/Prakash	Ashraf	Q.Named/Tawfik	Buffie	Turton	Buffie	Alawneh	Brunts	Shawa	Saltagi/McNeary
12-Nov	Naum	Aras/Ponaguet	Will	Shah/Ayoubi	Bullock/Prakash	Ashraf	Q.Named/Tawfik	Buffie	Turton	Buffie	Alawneh	Brunts	Shawa	Saltagi/McNeary
13-Nov	Naum	Aras/Ponaguet	Will	Shah/Ayoubi	Bullock/Prakash	Ashraf	Q.Named/Tawfik	Buffie	Turton	Buffie	Alawneh	Brunts	Shawa	Saltagi/McNeary
14-Nov	Naum	Aras/Ponaguet	Will	Shah/Ayoubi	Bullock/Prakash	Ashraf	Q.Named/Tawfik	Buffie	Turton	Buffie	Alawneh	Brunts	Shawa	Saltagi/McNeary
15-Nov	Naum	Aras/Ponaguet	Will	Shah/Ayoubi	Bullock/Prakash	Ashraf	Q.Named/Tawfik	Buffie	Turton	Buffie	Alawneh	Brunts	Shawa	Saltagi/McNeary
Evening Int Med. Call 5-8 PM Night Int Med Call 8PM-3AM										SNF'S EYE CALL 5-10 PM After 10PM Call Hospitalist Page				
Date	Internal Med ED Call 5-8	Internal Med ED Call 5-8	Internal Med ED Call 5-8	Internal Med ED Call 5-8	Pulmonary Evening Call	Pulmonary Evening Call	Swing Shift NP	SNF NP	SNF NP	SNF NP	SNF NP	SNF NP	SNF NP	SNF NP
9-Nov	Meyer	Meyer	Meyer	Meyer	Isacs	Isacs	Dick	Greenbaum	Boone	Boone	Boone	Boone	Boone	Boone
10-Nov	Meyer	Meyer	Meyer	Meyer	Isacs	Isacs	Greenbaum	Boone	Boone	Boone	Boone	Boone	Boone	Boone
11-Nov	Fuss/Gott	Ashraf	McNeary	McNeary	Nara	Nara	Greenbaum	Boone	Boone	Boone	Boone	Boone	Boone	Boone
12-Nov	Boone	Will/Prakash	Frederick/Jumbi	McNeary	Daily	Daily	Greenbaum	Boone	Boone	Boone	Boone	Boone	Boone	Boone
13-Nov	Get/Atchison	Ayoubi	Frederick/Jumbi	McNeary	Stelton	Stelton	Kerner	Atchison	Atchison	Atchison	Atchison	Atchison	Atchison	Atchison
14-Nov	Boone/Gott	Ashraf	Frederick/Jumbi	McNeary	Brunts	Brunts	Simon	Atchison	Atchison	Atchison	Atchison	Atchison	Atchison	Atchison
15-Nov	Boone	Will/Ayoubi	Frederick/Jumbi	Schlagi	Nara	Nara	Mounce	Atchison	Atchison	Atchison	Atchison	Atchison	Atchison	Atchison
ALL	ICU, SICU & CCU Calls	GO TO	to the	Interlist	on call	on call	Dipri Vyas							
ALL	PEDIATRIC	CALLS	GO TO	to the	Interlist	on call	Dipri Vyas							
9-Nov	SATURDAY	CLINIC	8:00 AM TO	12:00 PM	MOUNCE	MOUNCE								
Answering Service-Please call the On-call person on Saturdays at the office between 8 am and noon instead of paging - THANK YOU										INFECTIOUS DISEASE NIGHT CALL				
Date: 11/9 & 11/10/19	SFHH									INFECTIOUS DISEASE NIGHT CALL				
Saturday	9-Nov	POUNCE/ABDELHATEZ/NG/MANAS/BAPOUR/MORAD/VALLAB	GROSSER							INFECTIOUS DISEASE NIGHT CALL				
Sunday	10-Nov	POUNCE/ABDELHATEZ/NG/MANAS/BAPOUR/MORAD/VALLAB	GROSSER							INFECTIOUS DISEASE NIGHT CALL				
PHARM/CC	9-Nov	PRENS/SALHAD/POUNCE/TOJIN								INFECTIOUS DISEASE NIGHT CALL				
Saturday	10-Nov	PRENS/SALHAD/POUNCE/TOJIN								INFECTIOUS DISEASE NIGHT CALL				
Sunday	11-Nov	PRENS/SALHAD/POUNCE/TOJIN								INFECTIOUS DISEASE NIGHT CALL				
Sat/Sun	9/20-Nov	POUNCE/ABDELHATEZ/NG/MANAS/BAPOUR/MORAD/VALLAB	N/A							INFECTIOUS DISEASE NIGHT CALL				
INFECTIOUS DISEASE WEEKEND COVERAGE										INFECTIOUS DISEASE NIGHT CALL				
Date:	DESAI									INFECTIOUS DISEASE NIGHT CALL				
11-Nov	MUELLER													
12-Nov	MUELLER													
13-Nov	MUELLER													
14-Nov	WHITTS/D. SALTAGI													
15-Nov	POUNCE/WHITTS/KURKELA/D. SALTAGI/DESAI													
ER pages: Pulmonary-905-1536 Hosp-1805-0218 ID-905-1720										INFECTIOUS DISEASE NIGHT CALL				
SFHH Calls 7:00AM to 1:00 PM - Refer to Michele Smith or Sabrina Lee										INFECTIOUS DISEASE NIGHT CALL				
Questions: Terri Heller 885-8790 or Terri Marchetti 885-2860 ext 4809 *Moonlighter - Meeting - Trade										INFECTIOUS DISEASE NIGHT CALL				
SP-Kindred SouthPointe GWH-Greenwood Healthcare GM-Greenwood Meadows										INFECTIOUS DISEASE NIGHT CALL				
ALL *VFX SP, GWH, AND GWM calls from 5PM to 10PM see SNF's call schedule...After 10PM page Hospitalist										INFECTIOUS DISEASE NIGHT CALL				

Daily Office Physician Schedule

NAME	MON 11/11	TUE 11/12	WED 11/13	THU 11/14	FRI 11/15
Abdelhatez	GWO	GWO	GWO/OFF	GWO	GWO
Almad	GWO	GWO/SIP	GWO	GWO/SIP	GWO/OFF
Bender	GWO	GWO	GWO/OFF	GWO/OFF	OFF
Bratton	GWO	GWO	OFF	GWO	GWO
Brunts	CONSULTS	CONSULTS	CONSULTS	CONSULTS	CONSULTS
Cox	GWO/HOSP	HOSP	GWO/HOSP	HOSP	HOSP
Daily	GWO	GWO	GWO/OFF	GWO/OFF	GWO
Dave	GWO	GWO	GWO	GWO	GWO/PFF
Desai	HOSP	HOSP/GWO	HOSP	HOSP	VAC
Dick	GWO	GWO	GWO/OFF	GWO	GWO
Dudley	GWO	GWO	GWO	GWO	GWO
Greenbaum	GWO	GWO	GWO	GWO	GWO/OFF
Gregory	GWO	GWO	GWO	OFF	GWO
Hader	HOSP	GWO/HOSP	HOSP	GWO/HOSP	HOSP
Ionescu	GWO	GWO	GWO	GWO/OFF	GWO/OFF
Kerner	GWO	GWO	GWO	GWO/OFF	GWO
Khan	GWO/PROC	ADM/PROC	SURG/IPC	LC/SURG	GWO/IPC
Kukreja	GWO	GWO	GWO	GWO/OFF	VAC
Mason	GWO	GWO	GWO	OFF	GWO
Mounce	GWO	GWO	OFF	GWO	GWO
Mueller	VAC	VAC	VAC	GWO/OFF	GWO/OFF
Nara	AICU #2	AICU #2	AICU #2	AICU #2	AICU #2
Samuels	GWO	GWO	GWO	GWO/NAC	VAC/DF
Sharief	HOSP/GWO	HOSP	HOSP	HOSP/GWO	HOSP
Shawa	AICU #1	AICU #1	AICU #1	AICU #1	AICU #1
Simon	GWO	OFF	GWO	VAC	GWO
Stingl	GWO/ADM	GWO	GWO/SIP	GWO	GWO/SIP
Snyder	OFF	GWO	GWO	GWO	OFF
Vitay	GWO	GWO	GWO	GWO/OFF	GWO
D. Vyas	GWO	OFF	OFF/GWO	GWO/OFF	VAC
Vyas	GWO	GWO	GWO	GWO/OFF	VAC
Webb	VAC/OFF	GWO	GWO	GWO	GWO
White	GWO	GWO	OFF	GWO	GWO

IM Critical Care



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November 2019


### Commitment of Critical Care Physicians

Franciscan Health Indianapolis is committed to becoming a verified Level III Trauma Center through the American College of Surgeons.

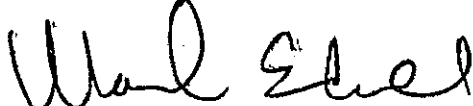
With this commitment, Indiana Internal Medicine Consultants (IIMC) and Center for Respiratory and Sleep Medicine (CRSM) acknowledge that if verification is not pursued within one (1) year of submitting the "in the ACS verification process" application and/or does not achieve ACS verification within two (2) years of the granting of the "in the ACS verification process" status that the hospital's "in the ACS verification process" will be immediately be revoked, become null and void and have no effect whatsoever.

A critical care liaison and trauma surgeons acknowledge and commit to the criterion expectations for a Level III Trauma Center. This includes, but not limited to credentialing, certification, continuing education, and adequate involvement in performance improvement. The multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions.

To this end, the critical care medicine liaison will be committed to a minimum of 50% attendance at the Trauma Operational Process Performance Improvement Committee ("TOPI") and a minimum of 50% attendance at the Trauma Patient Care Committee ("Trauma PCC") with one predetermined alternate allowed to attend the meetings in lieu of the liaison. A critical care medicine physician will be available in-house 24 hours a day seven (7) days a week with a response time within 30 minutes as needed.

  
\_\_\_\_\_  
Michael Snyder, MD, FCCP, Critical Care Liaison to Trauma

12/17/19  
Date

  
\_\_\_\_\_  
Mark Edwards, MD, FACS, Trauma Medical Director

12/12/19  
Date

Current Status: Active

PolicyStat ID: 6483026

Original: 7/1/2005

Last Reviewed: 7/5/2019

Last Revised: 7/5/2019

Next Review: 7/4/2022

Responsible Party: Mechelle Peck: Clinical

Nurse Specialist

Policy Area: Nursing

References: Procedure

Applicability: Franciscan Health

Indianapolis

Franciscan Health

Indianapolis at Carmel

Franciscan Health

Mooresville



## Rapid Response Team (Adult) Procedure

9/12/16 Franciscan Alliance hospital facility names were changed. See Hospital Listing document for new name changes and previous names.

### Keywords:

RRT, Pre-Code, Emergency Response, Rescue

### Purpose:

To outline the procedure for implementing a Rapid Response Team consultation.

### Scope:

**Inpatient areas:** Indianapolis, Mooresville and Carmel campuses. [Excludes Pediatrics, refer to Nursing Procedure, Rapid Response Team (Pediatric)].

**Outpatient areas:** For the safety of all patients that may potentially need assistance from the Rapid Response Team, the team will **ONLY** respond to calls from outpatient areas that are in the MAIN hospital building, which may include:

- Emergency Department
- Imaging Services
- Peri-Operative Services
- Cancer Care Centers including Infusion Clinic

**Indianapolis Campus:** Cardiac Testing, Laboratory, Wound Clinic, Pulmonary Function Laboratory

**Mooresville Campus:** Cardiac Testing, IMPACT center, Sleep lab Indiana Heart Physician's office, Endoscopy, Pulmonary Rehabilitation and Pulmonary Function Laboratory

**Carmel Campus:** Infusion Clinic, Radiology, Lab, Physical / Occupational Therapy, Cardiac Testing

## Responsible Persons:

Critical Care Registered Nurse (RN) and Respiratory Therapist (RT) trained as members of the Rapid Response Team (RRT).

**Carmel Campus:** Will have a designated ACLS provider code nurse / Rapid Response Team nurse that will respond to all inpatient and outpatient codes and rapid response calls as requested with assistance of available staff.<sup>1</sup>

**Indianapolis and Mooresville Campuses:** A Critical Care RN trained as a member of the RRT will be the primary RRT responder. Inpatient RRT RN will respond to inpatient RRT calls. For outpatient areas, the RRT RN will be supplied by the Emergency Department.<sup>1</sup>

## Definitions:

- A. Code Blue Team: The code blue team is summoned when a patient is found to be pulseless or apneic.
- B. Rapid Response Team: Franciscan Health Central Indiana will provide a preplanned response to medical crises that occur in in scope areas by surrounding the patient with a Critical Care setting regardless of their location. The goal of the Rapid Response Team is to prevent further deterioration of patients outside of a Critical Care area through rapid facilitation of critical care resources. The secondary purpose is to prevent futile resuscitation by addressing and assigning appropriate code status to those patients whom a change in code status may benefit, is appropriate, and is agreed upon by patient or proxy. There will be no order written in a patient's chart to remove a Rapid Response Team consultation as a possibility for any patient.<sup>1-3</sup>
- C. Rapid Response Team Members:<sup>1-3</sup>
  - 1. Critical Care Nurse: A pre-determined current ACLS provider, RRT trained RN.
  - 2. Respiratory Therapist (RT): A pre-determined current ACLS provider, RRT trained RT with a disposable or reasonable assignment while acting as the Rapid Response Team RT (Limited availability at Carmel Campus).

## Equipment:

As stated throughout and as needed per individual patient needs.

Use Order sets:

MED IP ADULT RAPID RESPONSE ORDERS # 1375

GEN ED SEPSIS ADULT INITIAL RESUSCITATION FOCUSED # 1336

GEN IP SPSIS ONGOING MANAGEMENT FOCUSED # 1046

## Procedure:

- A. **Criteria for Initiation of Rapid Response Team Call:** The following are criteria to serve as guidelines in initiating a Rapid Response Team Consultation:<sup>2,3</sup>

 1. Airway:

- a. Respiratory distress - new onset.
- b. Threatened airway.

**2. Breathing:**

- a. New onset respiratory rate greater than 28 breaths per minute.
- b. Respiratory rate less than eight (8) breaths per minute.
- c. Oxygen level less than 85% on oxygen - new onset and for more than five (5) minutes.
- d. Requirement of greater than 50% oxygen to keep saturation about 85% - new onset.
- e. Difficulty speaking.
- f. Naloxone (Narcan) use without immediate response. Refer to order set, **MED IP ADULT RAPID RESPONSE ORDERS # 1375.**

**3. Circulation:**

- a. Systolic Blood Pressure (SBP) less than 90 mm Hg (new onset) or greater than 180 mm Hg systolic/ Diastolic Blood Pressure (DBP) greater than or equal to 110 mm Hg with symptoms.
- b. Pulse rate greater than 130 beats per minute (bpm) or less than 40 bpm with new symptoms or any rate greater than 160 bpm.
- c. Patient complaint of chest pain (cardiac) / angina that is unresponsive to sublingual (SL) nitroglycerin (NTG). 12 lead ECG first prior to SL NTG; Refer to Nursing Policy, **Chest Pain / Angina Management Protocol.**

**4. Suspected myocardial infarction (chest pain / angina): Refer to Nursing Protocol, Chest Pain / Angina Management, then as indicated Nursing Policy, STEMI (ST-Elevation Myocardial Infarction) Urgent Catheterization.**

**5. Neurological:**

- a. Suspected acute stroke.
- b. Any unexplained change in level of consciousness.
- c. Sudden collapse.
- d. Sudden loss of movement (or weakness) or sensory changes of face, arm, or leg.
- e. Agitation or delirium for more than 10 minutes.
- f. New onset, repeated or prolonged seizures.

**6. Renal:**

- a. Change in urinary output to less than 50 mL in four (4) hours.

**7. Additional Criteria:**

- a. Concern about patient. Refer to Nursing Policy, **Rothman Index: Monitoring Patient Acuity.**
- b. Uncontrolled pain.
- c. Unable to obtain prompt assistance.
- d. Color change (of patient or extremity): pale, dusky, gray, or blue.
- e. Uncontrollable bleeding or large acute blood loss.
- f. Infection or suspected infection with two (2) or more Systemic Inflammatory Response Syndrome (SIRS) criteria plus one (1) sign of organ dysfunction:
  - i. Organ dysfunction defined as:

- a. Lactate greater than 2 mmol / L
- b. INR greater than 1.5
- c. aPTT greater than 60 seconds
- d. Platelet count less than 100,000
- e. Bilirubin greater than 2mg /dL
- f. Serum creatinine greater than 2 mg / dL
- g. Urine output less than 0.5mL / kg / hour × 2 hours
- h. Acute respiratory failure by need for new invasive or noninvasive ventilation
- i. Systolic blood pressure (SBP) less than 90 mm Hg, mean arterial pressure (MAP) less than 65 mm Hg, or decreased in SBP more than 40 mm Hg from previously recorded patient normal

**B. Initiation of Rapid Response Team Call:<sup>1,2</sup>**

1. Any member of the healthcare team or family / significant other (SO) who recognizes an impending crisis situation may initiate a call to the Rapid Response Team. An order is not required to initiate the Rapid Response Team.
2. Calling the Rapid Response Team to consult DOES NOT replace the phone call to the patient's physician / allied health professional (AHP) that ordinarily would and should be made.
3. The staff member initiating the team consultation will call the Critical Care RN and will remain with the patient until the Rapid Response Team has received an SBAR (Situation, Background, Assessment, and Recommendation) report. The nurse member of the Rapid Response Team will be responsible for notifying the RT and Family Practice Resident if available at specific campus.
4. The staff of the unit on which the patient resides will continue to supply support to the Rapid Response Team as necessary including communication of how they may be reached.
5. The Rapid Response Team will assess the patient and present situation and make recommendations / take actions as necessary. Refer to order set, **MED IP ADULT RAPID RESPONSE ORDERS # 1375**.
6. If the patient is in an outpatient area, the Rapid Response Team will assess the patient and present the situation and make recommendations / take actions as necessary before moving the patient to the Emergency Department or other patient disposition.
7. The appropriate attending physician / AHP will be notified of all recommendations / actions taken by the Rapid Response Team.
8. All communications will follow the SBAR process.
9. The Rapid Response Team will not coordinate or request a consult from a physician / AHP that is not already consulted for a patient.
10. The Rapid Response Team will follow all pages made with " \*44 " after the return phone number so the physician / AHP being paged will be aware of the urgency of the page.
11. Inpatient Units ( Excluding level 1 Critical Care Areas) if an **Immediate Transfer (i.e. patient requiring EMS transport to another facility; EMS arrival is expected to occur within 30 minutes of transport request)** is requested by physician / allied health professional then Rapid Response Nurse will be called to assist bedside nurse in the transfer process and remain with patient

until patient is either transferred to higher level of care ( e.g. ICU) or until paramedics take responsibility for the patient being transfer to another facility. The Rapid Response Team RN may assist with a patient transfer from within the hospital to critical care without being requested (i.e. when admitting notifies the unit that a transfer is coming in, the Rapid Response Team nurse may assist in orchestrating that move).

12. If a patient requires a higher level of care (i.e. a transfer to critical care) at least one (1) member of the Rapid Response Team will remain with the patient until and during transfer.

- **Special Note:** If the patient is to be transferred to another facility at least one (1) member of the Rapid Response Team will remain with the patient until the paramedics take responsibility for the patient or the nurse will escort the patient during ambulance transport. Refer to Nursing Policies, Transfer and Transport of Patient and Emergent / Non emergent Management and Transfer.

13. If the patient remains in their present location, the Rapid Response Team RN will follow up with that patient within four (4) hours either via phone consultation or physical presence. The Rapid Response Team nurse will call the Rapid Response Team RT or physician / AHP as necessary. If the patient's condition should worsen before this four (4) hour time period lapses, the patient's primary nurse is responsible for communicating such information to the patient's physician / AHP and / or Rapid Response Team as appropriate.

- C. **Nursing Actions:** Each time one (1) of the following is required a medical order is initiated per this policy, an order **MUST** be entered in the electronic medical record (EMR). Any hospital approved policy that applies to a specific patient may be utilized by the Rapid Response Team as appropriate (i.e. hypoglycemia protocol):<sup>2, 3</sup>

1. Labs:

- a. ABG
- b. CBC
- c. Hemogram
- d. BMP
- e. Magnesium
- f. Cardiac Enzymes (troponin)
- g. PT
- h. PTT
- i. Digoxin level (as appropriate based on medication history)
- j. Drug screen
- k. Type and Screen (T&S)
- l. Blood Cultures times two (2) for new onset fever of unknown origin.
- m. Urinalysis for Culture and Sensitivity for new onset fever of unknown origin.
- n. Point of care blood glucose level.
- o. Lactate
- p. Acetaminophen level (as appropriate based on medication history)

- 
- q. Aspirin level (as appropriate based on medication history)
  - r. Infection or suspected infection with two (2) or more SIRS criteria plus one (1) sign of organ dysfunction, Refer to Nursing Guideline, **Early Identification of Sepsis in the Adult Patient**:
    - i. Lactic acid panel (lactic acid STAT and timed in four (4) hours)
    - ii. Blood cultures STAT times two (2)
    - iii. Call physician / AHP for IV fluid bolus at 30 mL / kg and antibiotics
      - a. Refer to order sets:
        - **GEN ED SEPSIS ADULT INITIAL RESUSCITATION FOCUSED # 1336**
        - **GEN IP SEPSIS ONGOING MANAGEMENT FOCUSED # 1046**
2. Diagnostics:
- a. 12 Lead EKG
  - b. CXR for acute respiratory distress
  - c. Head CT without contrast for suspected stroke:
    - i. Mooresville Campus; requires a physician / AHP order
    - ii. Patients at Carmel Campus will be transferred.
3. Interventions:
- \* Change code status to meet wishes of patient and / or proxy.
4. Medication:
- a. Life threatening arrhythmia follow the current Advanced Cardiac Life Support<sup>4</sup> (ACLS) guidelines.
  - b. Decrease in urine output, defined as less than 50 mL in four (4) hours, IF urine output is greater than 500 mL / day at baseline:
    - i. Lactated Ringer's 500 mL IV bolus once - fluid challenge.<sup>5</sup> (if patient's potassium level is greater than 5 mEq / L, use 0.9% sodium chloride)
  - c. Acute pulmonary edema, defined as shortness of breath or difficulty breathing when supine:
    - i. Furosemide (Lasix) 40 mg intravenous push (IVP) once.
  - d. Seizure, delirium tremens, or Clinical Institute Withdrawal Assessment of Alcohol Scale - Revised (CIWA-Ar) greater than eight (8):
    - i. Lorazepam (Ativan) IVP once.
      - a. 1 mg for patients greater than or equal to 65 years old or history of hepatic insufficiency
      - b. 2 mg for patients less than 65 years old and no history of hepatic insufficiency
  - e. Suspected opioid overdose:
    - i. Naloxone (Narcan) 0.4 mg IVP once. Refer to order set, **MED IP ADULT RAPID RESPONSE ORDERS # 1375**.
  - f. Hypertension:
    - 1. Hypertensive emergency: SBP greater than 180 mm Hg or diastolic blood pressure (DBP)

greater than 110 mm Hg with target organ dysfunction (i.e. acute kidney injury / failure, heart failure exacerbation, obtundation).

- a. Indianapolis and Mooresville Campuses: Transfer to Level I Critical Care Unit
  - b. Carmel Campus: PACU or transfer
2. Labetalol (Trandate) 10 mg IVP every 10 minutes for SBP greater than 180 mm Hg or DBP greater than 110 mm Hg up to 30 mg.
  3. If SBP is still greater than 180 mm Hg or DBP greater than 110 mm Hg after 30 mg of labetalol (Trandate), start nicardipine continuous infusion.
    - a. Nicardipine continuous infusion 2.5 to 15 mg / hr, start at 5 mg / hour, and titrate per administration instructions in EMR function.
  4. Hypertensive urgency defined as SBP greater than 180 mm Hg or DBP greater than 110 mm Hg with NO target organ dysfunction:
    - a. Oral (preferred route): clonidine (Catapres) 0.1 mg by mouth (PO) once.
    - b. If the patient is unable to take PO, labetalol (Trandate) 10 mg IVP once.
- g. Hypotension: MAP less than 65 mm Hg or SBP less than 90 mm Hg.
1. Lactated Ringer's 500 mL IV bolus once (if patient's potassium level is greater than 5 mEq / L, use 0.9% sodium chloride); if blood pressure improves, may repeat once.
  2. If fluid bolus fails to correct blood pressure
    - a. Indianapolis and Mooresville Campuses: Transfer to Level I Critical Care Unit
    - b. Carmel Campus: PACU or transfer
  3. Start and Titrate:
    - a. Norepinephrine continuous infusion for hypotension without bradycardia (HR greater than or equal to 60)
      - i. Norepinephrine continuous infusion 2 to 30 mcg / min, start at 8 mcg / min, and titrate per administration instructions in EMR.
    - b. Dopamine continuous infusion for hypotension with bradycardia (HR less than 60).
      - i. Dopamine continuous infusion 5 to 20 mcg / kg / min, start at 2 mcg / kg / min, and titrate per administration instructions in EMR.
- h. Supraventricular (SVT) tachycardia, atrial fibrillation, or atrial flutter (other than sinus tach):
1. Follow current ACLS guideline for symptomatic or life threatening tachyarrhythmias.
  2. For stable supraventricular tachycardia (SVT), atrial fibrillation or atrial flutter:
    - a. Indianapolis and Mooresville Campuses: Transfer to Level I Critical Care Unit
    - b. Carmel Campus: PACU or transfer
  3. Start diltiazem (Cardizem) continuous infusion, bolus 5 mg IVP once then start at 5 mg / hour and titrate per administration instructions in EMR.

**D. Respiratory Therapy Actions:** In emergency situations, RT (when available at Carmel Campus) will take appropriate actions while the physician / AHP is being contacted and until orders are received. The following protocols will be utilized.<sup>2,3</sup>

1. The Oxygen Therapy Protocol.
2. The Bronchodilator Protocol (Adult and Pediatric).
3. Non-Invasive Positive Pressure Ventilation (BiPAP Protocol).
4. Intubation Privilege.
5. Laryngeal Mask Airway (LMA) placement Privilege.
6. Mechanical Ventilation (Adult).

**E. Quality Improvement Measures:** The following data will be collected and documented for process improvement after each call.<sup>4</sup>

1. Patient location before the call.
2. Patient location after the call.
3. Staff satisfaction with the call.
4. Time spent during the Rapid Response Team consultation / intervention.
5. What recommendation or interventions were made.
6. Reason why call was initiated.

## Documentation:

The Rapid Response Team will document the following in the patient's progress notes / electronic medical record (IP Rapid Response Progress Note):<sup>6</sup>

1. The situation—problem that initiated the call.
2. Background—history of present illness and DATA.
3. Reason for current admission and past medical history.
4. Medications and Allergies.
5. Assessment.
6. Recommendations and Interventions implemented.
7. Patient response to any intervention performed.

## References:

1. Smith PL, & McSweeney J. Organizational Perspectives on Rapid Response Team Structure, Function, and Cost, Leadership Dimension. 2016. doi: 10.1097/DCC.0000000000000222.
2. Chan P, Jain, R, Nallmothu, B, Berg R, Sasson, C. Rapid response teams: a systematic review and meta-analysis. *Arch Intern Med*. 2010; 170:18-26.
3. Mancini ME, Soar J, Bhanji J, et al. Part 12: education, implementation, and team: 2010 international consensus on cardiopulmonary resuscitation and emergency cardiovascular care science with treatment recommendations. *Circulation*, 2010; 122(suppl\_2):S539-581.
4. American Heart Association. Advanced Cardiac Life Support Manual. 2017. TX. AHA.
5. Self WH, Semler MV. Balanced crystalloids versus saline in critically ill adults. *NEJM*. 2018;378(9):819-828.

6. Winters BD, Weaver, SJ, Pfoh ER, Ting Y, Pham JC, Dy SM. Rapid-response systems as a patient safety strategy. *Ann Intern Med.* 2013; 158:417-425.

## **Bibliography:**

Franciscan Health Central Indiana Nursing Guideline, **Early Identification of Sepsis in the Adult Patient**  
Franciscan Health Central Indiana Nursing Policy, **Emergent / Non emergent Management and Transfer.**  
Franciscan Health Central Indiana Nursing Policy, **Rothman Index: Monitoring Patient Acuity.**  
Franciscan Health Central Indiana Nursing Policy, **STEMI (ST-Elevation Myocardial Infarction) Urgent Catheterization.**  
Franciscan Health Central Indiana Nursing Policy, **Transfer and Transport of Patient.**  
Franciscan Health Central Indiana Nursing Protocol, **Chest Pain / Angina Management.**  
Franciscan Health Central Indiana Nursing Policy, **Rapid Response Team (Pediatric).**

## **Review Panel:**

Bennett, Marci, MHA, BSN, RN, NE-BC, CPHQ, CCRN, Director Patient Care Services, Heart Center & Perioperative Services, Indianapolis Campus, - 05/2019.  
Breedlove, Emily, PharmD, BCPS, Cardiology Clinical Pharmacy Specialist, Indianapolis Campus, - 05/2019.  
Kavanagh, Jon, Paramedic, EMS Liaison, Central Indiana Region, - 06/2019.  
Knight, Elizabeth, BSN, RN, OCN, Quality Coordinator, Central Indiana Region, - 06/2019.  
Lowder, Melissa, DNP, RN, ACNS-BC, CCRN, Mooresville Campus, - 06/2019.  
Peck, Mechelle, DNP, RN, ACNS-BC, Critical Care Cardiovascular Clinical Nurse Specialist, Carmel, Indianapolis and Mooresville Campuses, - 06/2019.  
Wallace, Elizabeth, MSN, RN, Quality Coordinator II, - Carmel, Indianapolis, and Mooresville Campuses, - 06/2019.  
Wolverton, Cheryl, PhDc, RN, CCRN, NE-BC, Director of Critical Care Services, Indianapolis Campus, - 06/2019.

## **Committee Approvals:**

Critical Care Committee: - 05/1/2019.  
Clinical Practice Council: - 5/14/2019.  
Emergency Response Team Committee: - 05/13/2019.  
Nursing Executive Committee: - 05/2019.  
Pharmacy & Therapeutics Committee, Carmel / Indianapolis / Mooresville Campus: - 09/04/2018,  
Medical Executive Committee, Indianapolis Campus: - 06/20/2019,  
Medical Executive Committee, Mooresville Campus: - 06/12/2019.

Central Indiana Board of Directors: - 06/25/2019.

*If this policy does not yet have an electronic signature, please refer to the policy archives for a signed PDF version.*

## Attachments:

### Approval Signatures

Step Description	Approver	Date
	Agnes Therady: VP CNO	7/5/2019
	Stephanie Heckman: Clinical Nurse Specialist	6/20/2019
Clinical Practice Council	Lisa Hayden: Secretary II	6/17/2019
	Mechelle Peck: Clinical Nurse Specialist	6/3/2019

### Applicability

Franciscan Health Indianapolis, Franciscan Health Indianapolis at Carmel, Franciscan Health Mooresville

**St. Francis Hospital & Health Centers  
Plan for the Provision of Patient Care 2018-2019**

**Department/Unit Name**

Respiratory Care Services - Respiratory Therapy / Pulmonary Rehab / Pulmonary Function

**Campus**

Indianapolis, Mooresville, Carmel

**Director and Service Line Director Name**

Connie Little, M.S., RRT / Cheryl Wolverton, PhD, RN, CCRN

**Scope of Care and Services Provided**

Each clinical area will have a defined scope of care documented that includes:

- Type and ages of patients;
- Type of services most frequently provided (such as procedures, services)
- Hours of operation and method to insure services are available and accessible to meet patient needs

Respiratory Care includes the following departments: Respiratory Therapy a Carmel, Mooresville and Indianapolis Campuses, Pulmonary Function Testing (PFT) at Indianapolis and Mooresville, and Pulmonary Rehabilitation Services at IN & MV Campuses. Therapeutic and diagnostic services and education are provided to patients with acute/chronic respiratory and or cardiac impairment.

Our common diagnoses include:

- DRG 79, 89 Pneumonia
- DRG 88, 91, 92, 93 COPD
- DRG 96, 97, 98 Asthma
- DRG 475 Ventilator Support
- DRG 104, 105, 106, 107 Cardiac Bypass Surgery
- DRG 386, 387 Prematurity with Major Problems and/or RDS

Services Provided:

**Respiratory Care:**

- Oxygen therapy
- Treatment modalities; including nebulized medication delivery, chest physiotherapy
- Hyperinflation therapy
- Mechanical Ventilation
- Respiratory assessment and respiratory care protocols
- Arterial blood gas procurement and analysis
- Emergency treatment – CPR & Airway management

Services provided to adult, pediatric and neonatal patients at designated campus

Pulmonary Rehabilitation

- Patient Education / Home Oxygen Evaluations / Pulmonary Rehab Exercise Program
- Pulmonary Rehabilitation, including didactic and demonstrative education with exercise
- Home Diagnostic Services
- Smoking Cessation Intervention

Services are provided for patients of all ages at Indianapolis and Mooresville campus locations.

Pulmonary Function

- Diagnostic Testing
- Spirometry
- Total Pulmonary Function Testing - Flows, volumes, N2 Washout & Diffusion Capacity
- Bronchial Provocation
- Cardiopulmonary Exercise Testing – CPST
- Patient Education

PFT Services are provided for patients age 4 and older at Indianapolis & Mooresville.

Respiratory Care Services

Respiratory care is provided in the following areas:

Medicine Service Line (AICU, Medicine Units) and Adult In-patient Units  
Cardiac Service Line (CCU, SICU I and II, SPCU, PCU, Cath Lab, EP Lab and Chest Pain Clinic)  
Women and Children's Service Line ( Labor & Delivery, Post Partum, NICU, Pediatrics)  
Surgical Service Line (Post-Surgical Units, Surgery, PACU, AIU)  
Oncology Service Line (Oncology Unit)  
Ortho/Neuro Service Line (Ortho/Neuro Unit)  
Bone Marrow Transplant Unit  
Emergency Services (Carmel, Indianapolis and Mooresville)  
Respiratory Care Services- Pulmonary Rehabilitation ( Indianapolis, MV )  
Pulmonary Function Laboratory ( Indianapolis / Mooresville )  
Other outpatient areas as needed such as Medical Clinics, Radiology and Special Procedures

Credentials and Competency of Staff

Skill levels and scope of practice of personnel delivering services

The basic requirements for the CRTs and RRTs include:

- Current state license
- National credentials ( RRT, CRT or student employee with probationary license )
- Current CPR certification

- Current ACSL certification (if assigned to Critical Care or Emergency Department Services)
- Current NRP certification (if assigned to NICU or Mooresville as primary therapist)
- Current PALS certification (if assigned to Pediatrics or Emergency Services)
- Completion of orientation for assigned areas
- Current competency for assigned duties and areas

The basic requirements for the RC students include:

- Current enrollment in a Respiratory Therapy program and completion of one semester of clinical practice
- Current CPR (BLS) certification
- Completion of orientation for assigned areas
- Current competency for assigned duties and areas

The basic requirements for the CPFTs and RPFTs, include:

- Current state license
- Current CPR (BSL) certification
- Completion of orientation for assigned areas and procedures
- Current competency for assigned duties and areas

The basic requirements for the equipment technician and secretarial staff include:

- Completion of orientation for assigned areas
- Current competency for assigned duties and areas

### **Staffing Plans**

Staffing plans for patient care services are developed based on the level and scope of care provided and a determination of the skill mix and competency level of personnel that can most appropriately meet the needs of the patient.

Each clinical area has a formalized staffing plan that is reviewed annually taking into consideration the following: employee turnover, historical trends, benchmarking information, changes in the delivery of care model, changes in the standards of practice, performance assessment, performance improvement activities, patient satisfaction surveys, and changes in the customer needs/expectations.

Staffing is adjusted based on patient acuity, census, the number of units requiring coverage, and the level of activity required. Critical care units with patients on mechanical ventilation are staffed continuously 24 hours per day by a qualified RCP. Mooresville Hospital has a minimum staffing of 2 Respiratory Therapists 24 hours a day / 7 days per week. Carmel facility will be provided with a Respiratory Therapist whenever patients are admitted ( in-patient and/or out-patient ). Any additional staff needed for Mooresville and/or Carmel Hospitals will be provided by the Indianapolis Campus RT Department. Flexing up or down for census needs is assessed every 4-8 hours. The Pulmonary Function Lab is staffed on day shift Monday through Friday. The Emergency Service Department is staffed continuously with in-house Respiratory Therapists 24/7 at both Indianapolis and Mooresville Hospitals.

There is a minimum of one therapist qualified to provide endotracheal intubation on duty at all times, 24 hours per day, seven days a week at Indianapolis and Mooresville campuses. A therapist credentialed in intubation will always be staffed at Carmel when patients are on the premises ( in and/ or out-patients ).

The RCP patient care load is generally as follows 35-45 relative value units per therapist per 8-hour shift. These ratios are adjusted according to the following factors:

- Number of admissions, new orders, and discharges
- Minimal staffing required for mechanically ventilated patients

Staffing is evaluated every four hours – cancellations may occur in the four hour increments

Specialty Procedures requiring RT are usually prescheduled .

- Oscillator Care for EP Lab

Staffing variances are resolved according to the following:

**Staffing shortages:**

- PRN staff
- On call therapists ( NICU only )
- Off-duty staff or staff from another shift
- Agency staff should not be cancelled

**Staffing overages: Order in which to cancel or HC**

- Cancel Overtime staff
- Cancel PRN Staff
- Hospital Convenience time rotated among regular staff

In situations of unusual circumstances (i.e. blizzard), staffing will be determined based on the situation as well as acuity, census, and activity.

Distribution of personnel by credentialing:

**Respiratory Care**

CRT	12
RRT	145 ( varies 2-5 )
Student	4

**Pulmonary Function**

RPFT	3
RRT	1

**Pulmonary Rehabilitation**

CRT	2
RRT	11
RCP with additional education ( internship ) in exercise physiology	2

## **Performance Improvement Plan**

### **Quality dashboard goals and indicators**

#### **Respiratory Care and Pulmonary Rehabilitation**

##### **Quality Goals for 2018-2019**

1. Continue in hospital wide initiative for the reduction of Ventilator Associated Pneumonia and decrease length of stay in critical care units by monitoring:
  - Re-intubation rates
  - Respiratory failure treated with NIPPV that did not require mechanical ventilation or intubation
  - Unintended extubation rate
  - Ventilator hours after a positive daily weaning screen
2. Successful intubation by respiratory care staff in 2 attempts or less
3. Provide Respiratory Care Staff with continuing education opportunities
4. Maintain established productivity target
5. Maintain High Frequency Oscillator competency of NICU Staff
6. Maintain average post operative ventilator time of 6 hours or less in the Surgical Intensive Care Unit

##### **Indicators**

- Re-intubations < 48 hrs to be <7%.
- Respiratory Failure treated with NIPPV that did not require Mechanical Ventilation or Intubation goal >60%
- Ventilator hours after a positive daily screen  $\leq$  12 hours
- Unintended extubations 1.1-2.1
- 90% Compliance with successful intubation by Respiratory Care Staff in 2 attempts or less
- Three Continuing Education In-services will be provided for Respiratory Care Staff per year
- 90% Compliance with monthly clinical simulation competency for High Frequency Oscillator.
- Mean post operative ventilator time of less than 6 hours in the Surgical Intensive Care Unit.

#### **Pulmonary Function**

##### **Quality Goals for 2018-2019**

1. Maintain compliance of ATS standards for patient testing > 90%
2. Maintain productivity target
3. Decrease test result reporting turnaround time to primary care physician

**Indicators**

- 90% Compliance with ATS Standards for Patient **Spirometry** Testing
- 90% Compliance with ATS Standards for Patient **Static Lung** Testing
- 90% Compliance with ATS Standards for Patient **DLCO** Testing
- 90% Compliance with ATS Standards for Patient **Raw & Conductance** Testing
- Test turnaround time  $\leq 3$  days per quarter

# CT Scan and Conventional Radiography

CT scan and conventional radiography: There must be twenty-four (24) hour availability of CT scan and conventional radiography capabilities. There must also be a written letter of commitment from the hospital's Chief of Radiology.

a. Documentation required:

- i. Signed letter of commitment from Chief of Radiology and Trauma Medical Director.

Evidence:

- i. Signed letter of commitment from Radiology Medical Director and TMD
- ii. Plan for Provision of Patient Care for Imaging Services, stating 24 hour availability of CT and radiography

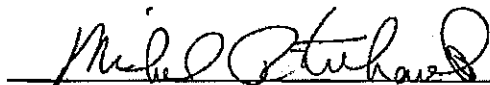
November 2019

### Commitment of Radiology

Franciscan Health Indianapolis is committed to becoming a verified Level III Trauma Center through the American College of Surgeons.

With this commitment, Radiology of Indiana acknowledges that if verification is not pursued within one (1) year of submitting the "in the ACS verification process" application and/or does not achieve ACS verification within two (2) years of the granting of the "in the ACS verification process" status that the hospital's "in the ACS verification process" will be immediately be revoked, become null and void and have no effect whatsoever.

To this end, a representative of radiological medicine will be committed to a minimum of 50% attendance at the Trauma Operational Process Performance Improvement Committee ("TOPI") and a minimum of 50% attendance at the Trauma Patient Care Committee ("Trauma PCC") with one predetermined alternate allowed to attend the meetings in lieu of the liaison. Radiologists will be involved in protocol development and trend analysis that relate to diagnostic imaging. A radiologist will be available within 30 minutes to read and interpret imaging studies.

  
Michael Kuharik, MD, Medical Director Imaging Services

11/26/2019  
Date

  
Mark Edwards, MD, FACS, Trauma Medical Director

11/27/19  
Date

**Franciscan Health – Central Indiana  
Plan for the Provision of Patient Care  
2019-2020**

**Department/Unit Name**

**Imaging Services**

**Campus**

**Indianapolis, Mooresville and Carmel**

**Off-site Imaging locations:**

**Manager & Director Name**

Christina Bocker, Administrative Director Imaging Services

- Jan Geuy, Manager Breast Imaging, Nuclear Medicine, PET/CT and Ultrasound.
- Mindee Junkins, Manager Indianapolis and Mooresville- (Diagnostic Radiology) and Carmel
- Lorie Nagy, Manager Interventional Radiology, CT, MRI and Vascular Access Team

**Scope of Care and Services Provided**

Each clinical area will have a defined scope of care documented that includes:

- Type and ages of patients;
- Type of services most frequently provided (such as procedures, services)
- Hours of operation and method to insure services are available and accessible to meet patient needs

The Department of Imaging Services provides diagnostic and therapeutic imaging exams to support all inpatient, outpatient and emergent patient services. The patient mix includes patients of any age.

**Staffing Mix**

Type and mix of staff required to provide services

Imaging Services utilize Radiologic Technologists, Nuclear Medicine Technologists, Ultrasound and Vascular Imaging Technologists, CT and MR Technologists, Breast Imaging Technologists and Registered Nurses. Transporters, radiology assistants and transcriptionists perform ancillary support to Imaging Departments.

**Credentials and Competency of Staff**

Skill levels and scope of practice of personnel delivering services

Basic requirements for all technologists, nurses, transporters and imaging support staff:

- Completion of orientation to area employed
- Current CPR certification (N/A for radiology assistants and transcriptionists)

Additional requirements for the Radiologic Technologist include:

- Registered by the ARRT
- Current state licensure

Additional requirements for the Nuclear Medicine Technologist include:

- Registered by the ARRT or CNMT
- Current state licensure

Additional requirements for the Ultrasound and Vascular Ultrasound Technologist include:

- RDMS, ARRT(S) or RVT
- Secondary certification within 12 months of hire (RVT, OB or AB)
- RVT or CCI (Vascular Lab)

Additional requirements for the Maternal Fetal Ultrasound Technologist include:

- RDMS OB certification
- NT certification within 12 months of hire

Additional requirements for the CT and MR Technologist include:

- Registered by the ARRT
- Current state licensure
- ARRT CT or MR certification within 12 months of hire

Additional requirements for the Interventional Technologist include:

- ACLS certification

Additional requirements for the PET CT Technologist include:

- Registered by the ARRT or CNMT
- Current state licensure
- NMTCB PET certification within 24 months of hire

Additional requirements for the Breast Imaging Technologist include:

- Registered by the ARRT
- Current state licensure
- ARRT Mammography certification

Additional requirements for the Interventional Radiology Nurse:

- ACLS and PALS certification
- Current non-restricted state licensure

Additional requirements for the Imaging Nurse:

- ACLS certification
- Current non-restricted state licensure

Additional requirements for the Transportation staff:

- High School Graduate

Additional requirements for Imaging Transcriptionists:

- High School Graduate

### Staffing Plans

Staffing plans for patient care services are developed based on the level and scope of care provided and a determination of the skill mix and competency level of personnel that can most appropriately meet the needs of the patient. Each clinical area has a formalized staffing plan that is reviewed annually taking into consideration the following: employee turnover, historical trends, benchmarking information, changes in the delivery of care model, changes in the standards of practice, performance assessment, performance improvement activities, patient satisfaction surveys, and changes in the customer needs/expectations.

### **Indianapolis Campus:**

**8111 S. Emerson Ave.  
Indianapolis, IN 46237**

Modality	Outpatient hours	On-call patient care hours
Diagnostic Radiology	Monday-Friday 7:00 a.m. – 8:00 p.m. Saturday 8:00 a.m.-12:00 p.m. Sunday-closed	There is Radiology coverage on Site 24/7 for emergency and inpatient care.
Bone Densitometry	Monday-Friday 8a.m. -5:00 p.m. Saturday-Sunday-closed	No emergent coverage provided.
Nuclear Medicine	Monday-Friday 8:00a.m.-4:00p.m. Saturday and Sunday closed	On-call coverage provided for all Emergent exams after hours.
PET/CT	Monday-Friday 7:00a.m.-4:00p.m. Saturday and Sunday closed	No emergent coverage provided.
Ultrasound	Monday-Friday 7:00 a.m.-7:00 p.m. Saturday 7:30a.m.-3:00p.m. Sunday closed	There is Ultrasound coverage on Site 24/7 for emergency and inpatient care.
CT	Monday-Friday 7:00 a.m.-9:00 p.m. Saturday 8:00 a.m.-3:00 p.m.	There is CT coverage on site 24/7 For emergency and inpatient care.
Breast Imaging	Monday-Friday 8:00 a.m.-4:00 p.m. Saturday 8:00 a.m.-3:00 p.m.	No emergent coverage provided.
MR	Monday-Friday 6:30 a.m.-9:00 p.m. Saturday- 8:00 a.m.-3:00 p.m. Sunday 8:00 a.m.-3:00 p.m.	On-call coverage provided for all emergent exams after hours
Interventional Radiology	Monday-Friday 8:00a.m. - 4:00p.m. Saturday and Sunday closed.	On-call coverage provided for all Emergent exams after hours.
Maternal Fetal Ultrasound	Monday-Friday 8:00a.m.-4:30p.m.	No emergent coverage provided

**Georgetown Imaging Center:**  
**4880 Century Plaza Rd. Suite 170**  
**Indianapolis, IN 46254**

Modality	Scheduled outpatient care hours	On-call patient care hours
Diagnostic Radiology	Monday-Friday 7:30a.m.-5:00p.m.	No emergent coverage provided
Bone Densitometry	Monday-Friday 7:30a.m.-5:00p.m.	No emergent coverage provided
Ultrasound	Monday-Friday 7:30a.m.-5:00p.m.	No emergent coverage provided
CT	Monday-Friday 7:30a.m.-5:00p.m.	No emergent coverage provided
Breast Imaging	Monday-Friday 7:30a.m.-5:00p.m.	No emergent coverage provided
MR	Monday-Friday 7:30a.m.-5:00p.m.	No emergent coverage provided

**Franklin Imaging Center:**  
**1300 W. Jefferson St. Suite C**  
**Franklin, IN 46131**

Modality	Scheduled outpatient care hours	On-call patient care hours
Diagnostic Radiology	Monday-Friday 8:00a.m.-4:30p.m.	No emergent coverage provided
Bone Densitometry	Monday-Friday 8:00a.m.-4:30p.m.	No emergent coverage provided
Cardiac Ultrasound	Thursday-Friday 8:00a.m.-4:30p.m.	No emergent coverage provided
CT	Monday-Friday 8:00a.m.-4:30p.m.	No emergent coverage provided
MR	Monday-Friday 8:00a.m.-4:30p.m.	No emergent coverage provided

**Revised:**

**Approved by:**

Kuharik, Michael, M.D., Medical Director Imaging Services Franciscan Health Indianapolis,

Merchun, Gregory A., M.D., Medical Director Imaging Services Franciscan Health Mooresville,

# Intensive Care Unit

**Intensive care unit:** There must be an intensive care unit with patient/nurse ratio not exceeding two to one (2:1) and appropriate resources to resuscitate and monitor injured patients

a. **Documentation required:**

- i. Scope of care/nursing standards/staffing guidelines for ICU that outlines nurse to patient ratios.
- ii. Equipment list for the ICU.

**Evidence:**

- i. Plan for the Provision of Patient Care for ICU, highlighting staffing ratio
- ii. Equipment list for ICU

**Franciscan St. Francis Health  
Plan for the Provision of Patient Care  
2019-2020**

**Department/Unit Name**

**Adult Intensive Care Unit (AICU)**

**Campus**

**Indianapolis**

**Manager & Director Name**

**Karen Hunt, MSN, RN, CCRN, Manager, Cheryl Lynn Wolverton, PhD, RN, CCRN, Director**

**\* Scope of Care and Services Provided \***

The 30 bed Adult Intensive Care Unit (AICU) provides 24 hour /7 day a week care for our acutely ill patients. The top 5 primary Diagnoses are:

1. Sepsis – (Multisystem Organ Failure)
2. Acute Respiratory Failure - (Acute Respiratory Distress, Pneumonia, Pulmonary Edema)
3. Overdose – (Poisonings, ETOH toxicity, unintentional and intentional overdose, suicide)
4. Mechanic Ventilator - (Chronic vents & trachs)
5. General – (Acute Renal Failure, ETOH toxicity, GI, neurosurgical)

The patients require 16.9 total productive hours of care per day. The staff mix is an all Registered Nurses (RN) staff with the support of Health Unit Coordinators (HUCs), and Patient Care Assistant/Patient Care Novice (PCA/PCN).

**Adult Intensive Care Unit (AICU)**

The Intensive Care Unit provides services that include both advanced monitoring and intensive treatment for the critically ill medical or surgical patient. The critically ill patients include those who require hemodynamic, neurological and physiologic monitoring or intensive treatments such as ventilator support, continuous vasoactive drug infusions, CRRT, or bedside tracheostomy. Examples of such patients may include those with:

- shock and related disorders
- multiple system organ failure
- pulmonary diagnoses including acute respiratory distress syndrome (ARDS), pneumonia and other respiratory infections, pulmonary embolism and respiratory failure
- renal problems including acute/chronic renal failure and acid-base disturbances
- critical neurological disorders including encephalopathy, complex or prolonged seizures, head injury or post-operative support-gastrointestinal emergencies including acute upper and lower GI bleeding or pancreatitis
- hepatic diagnoses such as liver failure
- endocrine diagnoses including ketoacidosis, hyperosmolar state or thyrotoxicosis
- infectious diseases
- management of acute ingestion of drugs and household poisonings
- behavioral disorders such ETOH abuse, suicidal attempt/ideations, mismanagement of psychotic medications
- unstable surgery patients requiring post-operative monitoring
- \* - critical trauma \*

### Staffing Mix

The AICU utilizes an all RN staff model of care. To support this staff are HUCs, and PCA/PCNs. The Director of Critical Care Services administratively oversees the AICU and the manager is responsible for the operations of the unit and personnel. The AICU leadership team includes the director, manager, patient care coordinators (PCCs), clinical nurse specialist, Unit Clinical Expert, and nurse educator.

### Credentials and Competency of Staff

The basic requirements for RNs include:

- Current IN state licensure
- Current CPR certification
- Current ACLS certification within six months of employment
- Completion of critical care orientation

The basic requirements for PCA/PCNs include:

- Current enrollment in a school of nursing with one semester of clinical experience (acute care experience) for PCN
- Current CPR certification
- Completion of orientation
- Completion of CNA certification by the Indiana Department of Health or successfully complete the organizations training program specific to their job role for PCA

Specialized competency (core group of staff trained) of RN staff:

- Continuous Renal Replacement Therapy (CRRT)
- Neuro Critical Care
- Rapid Response Team RN (RRT)

### Staffing Plans

The AICU utilizes the following personnel to provide care to meet the needs of their patients: RNs, and PCA/PCNs.

Staffing guidelines for productive hours per patient day are established based on current industry standards. Staffing is adjusted based on patient acuity, census, staffing skill and mix and the number of discharges and transfers (ADT churn). AICU maintains a 2:1 staffing ratio with a change to 1:1 when acuity dictates. Ratio will be adjusted based on acuity of patients (i.e. Med/surg, progressive level of care).

Staffing variances are resolved utilizing the following resources as applicable:

Staffing shortages:

- Staff from other critical care units (SICU, CCU, MPCU, SPCU, CPCU).
- Med-Surg nurses may float to AICU to care for lower acuity patients under the supervision of a critical care nurse
- PRN or other off-duty personnel from the AICU
- Nursing Resource Center Staff (NRC) -Critical Care or Med/Surg in-house registry

Staffing overages:

- Cancel in-house registry
- Cancel overtime
- Float staff to another unit needing staff with applicable competencies

- Implement Hospital Convenience Time

In situations where patient needs or staffing concerns arise, the AICU leadership will work with the medical director and other units within the hospital to assure safe care delivery.

The following is the distribution of personnel by skill level and shift:

- % RN Care/Shift
  - D 100%
  - E 100%
  - N 100%
- HUC, PCA/PCN – variable, goal HUC 24/7, and PCA/PCN as needed

**Performance Improvement Plan**

Quality dashboard goals and indicators

1. CLABSI/CAUTI
2. SAT & SBT
3. Restraints
4. Purposeful Rounding

Revised 1/23/2019 KDH

**Intensive Care Unit Equipment-30 bed AICU**

Essential equipment listed in *Resources for Optimal Care of the Injured Patient*

1. Continuous cardiac monitoring
  - a. Available in each patient room
  - b. 4 portable monitors- moving to new monitor platform where the bedside monitors will be able to transport with the patient for procedures-unsure of the timetable.
  - c. 3 code cart monitors
2. Pulse oximetry
  - a. Available in each patient room
  - b. 4 portable monitors
  - c. 3 code cart monitors
3. Capnography
  - a. 5 available (portable)- Hospital has 130 in house-able to obtain as needed
4. Pulmonary artery catheterization
5. Rapid infusers
  - a. Belmont Rapid infuser available
6. Patient rewarming
  - a. 6 Arctic sun thermoregulation shared between the critical care/ER units
7. Intracranial pressure monitoring
  - a. 1 Camino monitor

  
AICU Director

11-22-19

Date

NO. ANDREWS

MOORE, J. L.

CASPER

NO. 1000000

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NO. 1000000

256

# Blood Bank

**Blood bank:** A blood bank must be available twenty-four (24) hours per day with the ability to type and cross-match blood products, with adequate amounts of packed red blood cells (PRBC) and fresh frozen plasma (FFP) within fifteen (15) minutes. All centers must have massive transfusion protocol developed collaboratively between trauma services and the blood bank. All centers should consider having, platelets, cryoprecipitate and other proper clotting factors to meet the needs of injured patients.

a. Documentation required:

- i. Location of blood bank (in hospital or offsite address).
- ii. Policy/guideline that includes detail of products available and number of each product on site.
- iii. Copy of massive blood transfusion protocol.

Evidence:

- i. Location of blood bank
- ii. Guidelines:
  - a. Minimum Inventory of Blood Products for Indianapolis Campus
  - b. Transfusion support: stating products available within 15 minutes
- iii. Protocol: Massive Blood Transfusion

**Ancillary Services**  
**Indianapolis**

\* **A. Laboratory**  
*Location:* 2nd Floor by Women and Children's Center. \*

*Hours:* 24 hour availability

*Service:* Performs diagnostic testing to support all hospital inpatient and outpatient services, performs testing for hospital programs such as Occupational Health Service, Home Health/Hospice, Infection Control, and Cardiovascular Care Center.

\* The Laboratory acts as a primary reference lab and maintains a blood transfusion service in order \*  
to supply blood and blood components for hospital inpatients and outpatients. In addition, the transfusion service supplies blood products and services.

**B. Radiology**

*Location:* 1st Floor Outpatient Entrance Door 6 and 1<sup>st</sup> floor within Emergency Department

*Hours:* 24 Hour availability with immediate response to STAT calls.

Radiology reads all emergency films while patient remains in the ER before discharge.

*Service:* Services include but are not limited to: CT scan, Diagnostic Radiology, Interventional Radiology, MRI, Nuclear Medicine, Breast Center, Mammography, and Ultrasound, Fluoroscopy.

**C. Pharmacy**

*Location:* 1<sup>st</sup> floor, Door 2 near Gift Shop.

*Hours:* Pharmacist available 24 hours.

*Service:* In Patient Pharmacy, IV Admixture, provide drug information, assist in dosing medications, adjust medications for renal dysfunction & nutritional support.

**D. Surgery**

*Location:* 1<sup>st</sup> and 2<sup>nd</sup> floors, Door 6

*Hours:* Monday-Friday 8:00AM-4:30PM /Weekends on call if needed. 24 hour short stay beds available if needed

*Service:* Anesthesia, Recovery, Ambulatory Surgery, Endoscopy,

**E. Labor and Delivery**

*Location:* 2nd Floor Door 2, Women and Children's Center

*Hours:* 24 hour availability with on call in-house Family Practice residents

*Service:* Labor and Delivery, Bereavement Support, Post-Partum.

**F. Respiratory Therapy**

*Location:* Basement of the Heart Center.

*Hours:* 24 hour availability with immediate response to STAT calls.

*Service:* Respiratory Care, Pulmonary Care, Wellness Programs,

Current Status: Active

PolicyStat ID: 5604935



Origination: 8/1/1996  
Effective: 11/7/2018  
Approved: 11/7/2018  
Last Revised: 11/7/2018  
Expires: 11/6/2020  
Owner: Stacy Dickerson  
Policy Area: Blood Bank  
References:  
Applicability: Alverno Franciscan Health  
Indianapolis

## Minimum Inventory of Blood Products for Indianapolis Campus

Section: Blood Bank

Document Type: Policy

### PURPOSE:

The Blood Bank inventory is checked daily on every shift to ensure that an adequate supply is available for patients needs.

### POLICY:

This inventory is a guideline, however technologists should consider ordering products if counts fall below these numbers.

### PROCEDURE:

A suggested minimum inventory of available units is as follows:

- 30 O Rh Positive LRPC in Blood Bank
- 5 O Rh Positive LRPC in ED trauma
- 25 A Rh Positive LRPC in Blood Bank
- 15 O Rh Negative LRPC in Blood Bank
- 5 O Rh Negative LRPC in ED trauma
- 2 O Rh Negative LRPC in Blood Bank for emergency release
- 1 O Rh Negative LRPC, less than 10 days old, irradiated within 7 days, CMV negative, with aliquot bags attached (reserved for emergent transfusions for infants)
- 2 O Negative LRPC, irradiated in Blood Bank
- 14 A Rh Negative LRPC in Blood Bank
- 3 A Liquid Plasma, irradiated in Blood Bank
- 3 A Liquid Plasma, irradiated in ED trauma
- 20 O FFP
- 20 A FFP
- 10 B FFP
- 10 AB FFP
- 12 Pooled Cryoprecipitate - Any type
- 1 AB-Pooled Cryoprecipitate (reserved for emergent transfusions for infants)
- 3 Plateletpheresis

## REFERENCES:

AABB, *Standards for Blood Banks and Transfusion Services*, 31th ed., Bethesda, MD: 2018, p. 14-15.

AABB, *Technical Manual*, 19th ed., Bethesda, MD: 2017, pp. 475, 479-481, 529,

## FORMS:

Sign: BB - Indianapolis Campus Minimum Inventory Charts

Form: BB - Blood Inventory Check

## REVISIONS:

Date	Reason for Revision/Revised by:
4/30/2010	Original author: Debra Berner, MT (ASCP) Changing inventory from single cryoprecipitate to pooled cryoprecipitate. Adding O pos LRPC, irradiated to inventory. Changing policy format. Revised: Kathy Rippy, MT(AAB)
8/26/11	Minor template changes for PolicyStat. Written by author was changed to current leadership. Hospital name changed from St. Francis Hospital and Health Centers to Franciscan St. Francis Health. No content changes. Stacy Dickerson
12/13/12	Changed levels to meet the needs of patients after hospitals merged. S. Dickerson
1/10/13	Added CMV LRPC to inventory. Stacy Dickerson
11/1/13	Removed CMV products from inventory, adjusted minimum levels. Stacy Dickerson
12/17/13	Hyperlink Signs to policy. Stacy Dickerson
5/28/14	Changed to add irradiated, pc and irradiated, pltp into minimum inventory. Stacy Dickerson
6/9/16	Added Liquid Plasma, Hyperlink to Blood Inventory Check Form. Updated references. Stacy Dickerson
9/5/18	Updated Liquid Plasma to Irradiated, Cryoprecipitate - Any type. Stacy Dickerson
10/31/18	No content changes, re-arranged data per staff request. Stacy Dickerson
11/7/18	No content changes, fixed typo. Stacy Dickerson

## Attachments:

### Approval Signatures

Approver	Date
Stacy Dickerson	11/7/2018

## **Applicability**

Alverno Franciscan Health Indianapolis

Current Status: Active

PolicyStat ID: 5578887



Origination: 2/13/2014  
Effective: 11/13/2018  
Approved: 11/13/2018  
Last Revised: 11/13/2018  
Expires: 11/12/2020  
Owner: Stacy Dickerson  
Policy Area: Blood Bank  
References:  
Applicability: Alverno Franciscan Health  
Indianapolis  
Alverno Franciscan Health Carmel  
Alverno Franciscan Health  
Mooresville

## Transfusion Support

Section:

Document Type: Policy

### Purpose:

This policy defines the understanding between the Blood Bank and the clinical areas with regards to the expectations of turn-around time, requests for patients with special transfusion needs (i.e. irradiated, CMV negative, Hemoglobin S negative, antigen negative), notifications of expected delays, and transportation of products. These items have been established and acknowledged by the Medical Staff, Laboratory/Transfusion Service Medical Director, and Hospital Administration.

### Policy:

- **BLOOD PRODUCTS:**
  - **LEUKOREduced RED BLOOD CELL PRODUCTS:**
    - Type and Screen with a "Prepare for Leukoreduced Red Cell Order" - patient with no unexpected antibodies and no special requests - One (1) hour from time of receipt of patient specimen.
      - Patients with unexpected antibodies or a history of antibodies - time will depend on the complexity of the workup, what antigens need to be honored and the frequency of the antigens in the population.
    - Additional Red Cells on a patient who has a completed in-date type and screen specimen in the Blood Bank (no unexpected antibodies, no special requests) - Ten (10) minutes.
    - Uncrossmatched O Negative Red Cells - Available for immediate release - Ten (10) minutes.
    - Uncrossmatched, type specific Red Cells - Fifteen (15) minutes from time of receipt of patient specimen.
  - **LEUKOREduced PLATELETS:**
    - Patient must have a blood type in Blood Bank History.
    - All products are single donor apheresis. Pooled random donor platelets are not utilized.
    - Indianapolis and Mooresville Campuses - Platelets are kept on site - Fifteen (15) minutes.
    - Carmel Campus - Platelets are not kept on site and will need to be ordered from Indianapolis Campus or Indiana Blood Center - Two (2) hours.
    - HLA or SPRCA matched platelets are available by special request from Indiana Blood Center.
      - Additional testing must be completed.
      - Availability will depend on the complexity of the workup.
      - In some cases, a donor will need to be located, drawn and tested.
      - It may take several days to have these products available.
  - **PLASMA:**
    - Patient must have a blood type in Blood Bank History.
    - Product is stored frozen and must be thawed - Thirty (30) minutes.
    - Indianapolis Campus - Irradiated Liquid Plasma is available for trauma or emergent needs. If irradiated liquid plasma is not in inventory, thawed plasma will be prepared and available for emergent needs.
  - **CRYOPRECIPITATE:**

- Patient must have a blood type in Blood Bank History.
- Only pooled products are offered - pooled in groups of five (5).
- Product is stored frozen and must be thawed - **Twenty-five (25) minutes.**
- **SPECIAL REQUESTS:**
  - Irradiation:
    - Indianapolis Campus - a blood irradiator is on site - **Fifteen (15) minutes.**
    - Carmel and Mooresville Campuses - no blood irradiator is on site. A limited number of Irradiated Leukoreduced Red Cell Products are at each site. If additional products needed, they will need to be ordered from Indianapolis Campus or Indiana Blood Center - **Two (2) hours.**
  - Washed Products:
    - Timing with transfusion personnel is critical - as products have a shortened expiration time after Indiana Blood Center starts to process the unit.
      - Red cell products expire within 24 hours after washing process begins.
      - Platelet products expire within 4 hours after washing process begins.
      - Indiana Blood Center will require advanced notice (several hours) for this type of request.
  - Other requests will depend on timing of testing, processing of product, and availability of product. (i.e. CMV Negative, Hemoglobin S negative, IgA deficient, deglycerolizing frozen product).
    - Transportation time - **Two (2) hours.**
- **DELAYS:**
  - When there will be an unexpected delay in the availability of blood products due to compatibility problems or available inventory, the Blood Bank will notify the nursing area or the physician of the delay and the expected time frame of availability.
  - In situations of a **critical blood shortage**, follow established hospital administrative policy 950.77.

## References:

- AABB, *Standards for Blood Banks and Transfusion Services*, 31st ed., Bethesda, MD:2018, p. 2.
- AABB, *Technical Manual*, 19th ed., Bethesda, MD: 2017, pp.491-492.
- College of American Pathologists Accreditation Standard, TRM.30866.

## Revisions:

Date	Reason for Revision/Revised by:
2/25/14	Previously approved by Medical Executive Committee. Recommendation made by Medical Board to eliminate range of time (90 minutes to 2 hours) and state one time (2 hours). Dr. Doehring states - minor clarification, no need to have Medical Executive Committee approve this minor clarification. Stacy Dickerson
9/5/18	Changed type specific to 15 minutes. Added irradiated liquid plasma, updated other campuses to having small inventory of irradiated LRPC.
10/31/18	Changed requirement for plasma - ABO RH in history. Also expanded expiration times for washed products. Stacy Dickerson

## Attachments:

### Approval Signatures

Approver	Date
Stacy Dickerson	11/13/2018

**Approver****Date**

Dr. Ann Marshall, Medical Director

11/12/2018

Lindsey Danny

11/7/2018

**Applicability**

Alverno Franciscan Health Carmel, Alverno Franciscan Health Indianapolis, Alverno Franciscan Health Mooresville

Current Status: Active



**Franciscan**  
ALLIANCE

PolicyStat ID: 6169017

Original: 11/4/2015

Last Reviewed: 7/5/2019

Last Revised: 7/5/2019

Next Review: 7/4/2022

Responsible Party: Melissa Lowder: Clinical  
Nurse Specialist

Policy Area: Nursing

References: Protocol

Applicability: Franciscan Health  
Indianapolis  
Franciscan Health  
Mooresville

## Massive Blood Transfusion Protocol

9/12/16 Franciscan Alliance hospital facility names were changed. See Hospital Listing document for new name changes and previous names.

### Keywords:

Trauma, MTP, MBTP, Bleeding

### Purpose:

To outline a standard process for safe, rapid preparation and delivery of blood products and coagulation factors for the patient experiencing massive hemorrhage.

To prevent the anticipated complications that may occur as a result of massive transfusion.

To conserve valuable blood components while ensuring safe and rapid administration of blood.

This protocol meets the following ACS- COT Criteria Deficiency: 11-84

### Scope:

Emergency Department (ED), Perioperative Services, Obstetrics (OB), Critical Care Level 1, and Blood Bank

### Responsible Persons:

Emergency Department Physicians, Surgeons, Obstetricians, Anesthesiologists, Internal Medicine Physicians, Registered Nurse (RN) and Blood Bank Personnel

### Equipment:

As stated throughout.

#### Use Hospital Forms:

Emergent Blood Transfusion Record, # 217-008

Massive Blood Transfusion Record #215-002

## Definitions:

- A. **Cryoprecipitate:** Contains concentrated levels of fibrinogen, factor VIII, Factor XIII, and fibronectin. Product is supplied in pools of five (5). Product must be infused within six (6) hours of thawing.
- B. **Incompatible blood:** Donor blood that has been found to be incompatible either serologically or electronically with the patient's sample.
- C. **Leukoreduced Apheresis platelet (LR-PLTPH):** Also known as single donor platelet that is equivalent to six to eight (6 to 8) pooled random platelets (contains  $3.5$  to  $4 \times 10^{11}$  platelets per bag and 100 to 500 mL of plasma). Product is pre-filtered to remove leukocytes
- D. **Leukoreduced Red Packed Blood Cells (LRPC):** LRPC's consist of red blood cells concentrated from whole blood donations. Product is pre-filtered to remove leukocytes. Each unit contains 42.5 to 80 g of hemoglobin or 128 to 275 mL of pure red cells. LRPC's must be compatible with patient's ABO type and cross-matched to confirm compatibility. Uncross-matched units may be released with physician approval.
- E. **Massive blood transfusion (MBTP or MTP):** defined as
  1. Any occurrence where there is anticipated to be a loss of greater than or equal to one (1) total blood volume over one to three (1 to 3) hours OR
  2. More than 10 units of RBCs transfused within 24 hours OR
  3. The acute administration of four to five (4 to 5) units of RBCs in one (1) hour<sup>1,4,5,6,8</sup> OR
  4. Obstetric or postpartum patients with a cumulative blood loss of greater than or equal to 1500 mL, greater than two (2) units of PRBC's given, unstable vital signs or suspicion of DIC.<sup>3</sup>
- F. **Mismatched blood:** Donor blood that is a major mismatch with the patient's blood type (i.e. Group A Rh positive donor RBC's transfused to a group O Rh positive patient)
- G. **Plasma:** Aqueous part of blood that contains functional quantities of all coagulation factors. Labile coagulation factors vary on product type. Expiration dates vary on product type.
- H. **Plasmatyte:** An alternative balanced solution containing electrolyte, osmolarity, and pH concentrations similar to blood plasma.<sup>13</sup>
- I. **Prothrombin Complex Concentrate (PCC):** Is prepared from human plasma and contains factors II, VII, IX, and X, and antithrombotic proteins C and S. The potency of PCC is defined by content of factor IX. PCC is FDA-approved for urgent reversal of Vitamin K antagonist (VKA) therapy in patients with acute major bleeding or need for urgent surgery or invasive procedure.<sup>12</sup>
- J. **Transfusionist:** Individual(s) transfusing the patient.
- K. **Tranexamic Acid (TXA):** A hemostatic agent with actions similar to those of aminocaproic acid, but approximately 10 times more potent.
- L. **Type compatible blood:** Donor blood that is not identical to the patient's blood type, but is compatible for transfusion (i.e. O Rh positive donor RBC's transfused to a group A Rh positive patient).
- M. **Type specific blood:** Donor blood that is the identical blood type of the recipient.
- N. **Uncross-matched blood:** Donor blood that has not been cross-matched either serologically or electronically with the patient's sample.

## Procedure:

- A. Consider Nursing Guideline, **Acute Bleeding**, for the actively bleeding patient, but the Massive Blood Transfusion Protocol is not immediately indicated.
- B. The Nursing Protocol, **Massive Blood Transfusion (MBTP or MTP)** is to be initiated and terminated by the attending physician only.<sup>2,7</sup>
- C. Criteria to trigger the activation of the MBTP should be one or more of the following:
  - 1. ABC scoring system for trauma patient exhibiting greater than or equal to two (2) of the following clinical triggers:<sup>2,7</sup>
    - a. **Trauma Clinical Triggers**
      - i. HR greater than 120 (0 = no; 1 = yes)
      - ii. SBP less than 90 (0 = no; 1 = yes)
      - iii. Positive Focused Assessment with Sonography for Trauma (FAST: 0 = no; 1 = yes)
      - iv. Penetrating torso injury (0 = no; 1 = yes)
      - v. **Score of two (2) or more warrants massive transfusion activation**
  - 2. Persistent hemodynamic instability<sup>2</sup>
  - 3. Active bleeding requiring operation or angioembolization<sup>2</sup>
  - 4. Obstetric Hemorrhage:<sup>3</sup>
    - a. Refer to Nursing Protocol, **Obstetric Hemorrhage**
    - b. A cumulative blood loss of greater than or equal to 1500 mL, greater than two (2) units of PRBC's given, unstable vital signs or suspicion of DIC<sup>3</sup>
    - c. Clinical triggers: surveillance and intervention:
      - i. greater than 15% change in vital signs or
      - ii. Heart rate greater than or equal to 110
      - iii. Blood Pressure less than or equal to 85/45
      - iv. Oxygen Saturation less than 95%
      - v. Continued increased bleeding during recovery or postpartum
- D. To expedite the provision of blood components, special component processing such as CMV negative, Fresh, Washed, HLA matched, Antigen-matched, and / or Irradiated blood will not be provided.
- E. The MBTP does not preclude the ordering of other blood products, factors, or pharmaceuticals. Tranexamic acid (TXA) infusion should be considered when not contraindicated.<sup>2</sup>
- F. The Blood Bank must be called as soon as possible when a MBTP has been activated. There will be a dedicated person on the nursing unit and in the blood bank that will be the contacts during the MBTP. The dedicated Blood Bank technologist will also coordinate activities in the Blood Bank.
- G. Once the order has been received to initiate the MBTP, call Blood Bank with the following information:
  - 1. Patient full name (if known)
  - 2. Medical Record Number OR Date of Birth (if known)

3. Gender and approximate age (if Date of Birth is not known)
  4. Blood Bank Identification Number
  5. Location of Patient
  6. Physician activating MBTP
  7. Name and phone number for the dedicated contact person
- H. Upon initiation of the MBTP, the Blood Bank will prepare the first pack of products in the ratios defined in the chart below for an adult patient. (Pediatric doses are listed at the end of the protocol).
1. The first pack will be ready within 15 minutes of notification.<sup>2</sup>
  2. ABO type specific or type compatible RBC's will be issued unless time does not allow, in which case Group O RBC's will be issued. Rh positive will be issued for females greater than 50 years old and all males.<sup>1,2</sup>
  3. ABO specific plasma will be issued unless time does not allow, in which case Group A plasma will be issued.<sup>2</sup> Cryoprecipitate may be added as needed. For OB patients cryoprecipitate may be indicated when fibrinogen level falls below 100 g/dL.<sup>3</sup>
  4. Each pack will contain the following products:<sup>1,2,4,5,6,8,9</sup>
    - a. Five (5) leukoreduced packed RBCs (LRPCs)
    - b. Five (5) plasma (may be liquid or thawed)
    - c. One (1) leukoreduced apheresis platelet (LR-PLTPH)
      - **Special Note:** Only the Emergency Department at the Indianapolis campus will have an on-site refrigerator for the MBTP in the trauma room. The first pack of LRPC and plasma will be pulled from this refrigerator. LR-PLTPH will need to be sent from Blood Bank. An *immediate* call to Blood Bank is required to meet current patient needs and to restock the trauma room refrigerator.
  5. Blood Bank will notify the dedicated contact once the blood products are ready for issue.
  6. Transporting personnel will present issue card to Blood Bank when picking up blood products.
  7. Transfusion of blood components is one (1) unit of LRPC alternating with one (1) unit of plasma.
    - a. This is given as a one to one (1:1) ratio. When LR-PLTPH or Cryoprecipitate arrive to room, they are to be transfused within 30 minutes of issue time.
    - b. This sequence continues until the MBTP is ordered to be stopped by the attending physician.
      - **Special Note:** LR-PLTPH and Cryoprecipitate should not be given through blood warmer / rapid infuser.<sup>2</sup>
  8. Blood will be supplied as uncross-matched.
    - a. If it is not possible to wait for cross-matched blood, then the "Release of Blood from Blood Bank" on the Emergent Blood Transfusion Record, # 217-008 must be signed by the physician.
    - b. Signature can occur after the resolution of the clinical crisis.
  9. Once the first pack has been issued, Blood Bank will prepare the next pack. This process will continue until Blood Bank is notified the MBTP has been discontinued.
  10. Documentation of MBTP units of blood / blood products given will be recorded on the Massive Blood Transfusion Record, #215-002.

I. The following initial lab assays will be drawn:<sup>2,8,9</sup>

1. Type and Screen
2. PT / INR
3. PTT
4. D-Dimer
5. Fibrinogen
6. CBC
7. BMP
8. ABG

J. The Blood Bank sample must be drawn according to Laboratory Protocol, **Blood Bank Patient Identification** at the earliest time possible to provide type specific components. The sample must also be of adequate volume to allow for subsequent testing if unexpected antibodies are detected upon screening. If the antibody screen is positive, the dedicated contact person will be notified immediately of the findings.

1. If during testing, it is determined the patient has received blood products that are incompatible, the attending physician and the Blood Bank Medical Director will be notified immediately
2. Blood draws for coagulation may be ordered by the physicians throughout the duration of the MBTP situation. Labs to be ordered by the physician every 60 minutes while MBTP is active include:<sup>2</sup>

- a. Ionized Calcium
- b. Magnesium
- c. PT / INR
- d. PTT
- e. D-Dimer
- f. Fibrinogen
- g. CBC
- h. BMP
- i. ABG

- **Special Note:** Additional ongoing laboratory studies after the MBTP is discontinued should be ordered per the physician.

K. The decision to discontinue the MBTP will be based on the evaluation of patient stability and the ongoing severity of bleeding. The physician in charge should consider stopping the MBTP when:<sup>2</sup>

1. There is recognition that further resuscitation is futile.
2. Surgical bleeding has been controlled in the operating room OR there is radiographic and physiologic evidence of bleeding control after angioembolization.
3. The patient no longer appears to need all three (3) blood products (LRPC, Plasma, LR-PLTPH).
  - a. Red Cell transfusions not indicated for hemoglobin greater than or equal to 10 g/dL.
  - b. Plasma transfusions not indicated for prothrombin time (PT) less than 18 seconds

- c. Plasma transfusions not indicated for partial prothrombin time (aPTT) less than 35 seconds
- d. Platelet transfusions not indicated for platelet count greater than  $150 \times 10^9$
- e. Cryoprecipitate or fibrinogen concentrate not indicated for fibrinogen greater than 180 g/dL.
- L. If Blood Bank does not have any communication from the dedicated contact person for 45 minutes, the dedicated Blood Bank technologist will ask for an update.
- M. Storage and stability of blood products:
  - 1. All LRPC and plasma products shall remain stored in the MBTP cooler(s) with ice packs until they are ready for immediate transfusion.<sup>2</sup> Storage coolers can be utilized for four (4) hours as long as the lids are kept completely closed. Temperature indicators will be used to monitor the storage temperature of LRPC products.
  - 2. Platelets and Cryoprecipitate are **NOT** to be refrigerated or cooled. These products should be given within 30 minutes of issue time and should not be hung through a blood warmer / rapid infuser.<sup>2</sup>
  - 3. All unused blood products **MUST** be returned to Blood Bank in the appropriate transport device as soon as possible following the discontinuation of the MBTP in order to conserve resources.<sup>2</sup>
- N. Blood inventory levels:
  - 1. The Blood Bank will maintain adequate inventory in house to insure that type-specific and / or type-compatible blood components are made available in a timely manner.
  - 2. The Blood Bank will coordinate with the blood supplier to maintain inventory of blood components.
  - 3. The Blood Bank Medical Director will consult with the attending physician or the designee if the inventory of compatible (type-specific and type-compatible) blood is in danger of being depleted.
  - 4. Blood Bank Medical Director will consult with attending physician within 72 hours if Rh negative female with child bearing potential, less than 51 years old has received Rh positive LRPC, LR-PLTPH, or liquid plasma. Consultation will include the possible therapeutic options for the prevention of Rh allo-immunization.<sup>1</sup>
- O. Patient will be monitored for adverse outcomes during and after the initiation of MBTP. Adverse outcomes may be due to traumatic injury or adverse reactions to blood products and may include:<sup>1,2</sup>
  - 1. Citrate toxicity, manifested by hypocalcemia and hypomagnesaemia
  - 2. Hyperkalemia
  - 3. Acidosis
  - 4. Hypothermia
  - 5. Transfusion Related Acute Lung Injury (TRALI)
  - 6. Transfusion Associated Circulatory Overload (TACO)
  - 7. Acute traumatic coagulopathy
- P. The Transfusion Committee, will monitor and evaluate outcomes of all MBTP protocol with assistance of the Trauma Operational Process Performance Committee (TOPI) for those trauma related MBTP.<sup>5</sup>
  - 1. Performance indicators include (but are not limited to):
    - a. Compliance with clinical triggers (ABC score)
    - b. Appropriateness of MBTP initiation

- c. Time from calling MBTP to infusion of first LRPC and first plasma<sup>2</sup>
- d. Documentation of order
- e. Maintenance of component ratios<sup>2</sup>
- f. Labs drawn according to schedule
- g. Time to receipt of a specimen for Type and Screen
- h. Lab turnaround times
- i. Documentation of termination of MBTP<sup>2</sup>
- j. Product waste<sup>2</sup>
- k. Return of product

**Q. Pediatric cCases:**

1. The need for MBTP is indicated when it is anticipated that the patient has lost or may lose greater than 40 mL/kg of blood volume and will require rapid infusion of massive volumes of blood and blood components.
2. The following information will be provided to Blood Bank:
  - a. Patient full name (if known)
  - b. Medical Record Number OR Date of Birth (if known)
  - c. Gender and approximate age (if Date of Birth is not known)
  - d. Weight
  - e. Blood Bank Identification Number
  - f. Location of Patient
  - g. Physician activating MBTP
  - h. Name and phone number for the dedicated contact person
3. The freshest red cells available will be provided for children less than 17 kg<sup>10</sup>
4. Prepare weight-based dose as needed at a 2:1 red cell to plasma ratio<sup>10</sup>

Component	Category A Less than 17 kg	Category B 17kg – 40 kg	Category C Greater than 40 kg
LRPC	2	4	8
Plasma	1	2	4
LR-PLTPH	½ (or 1 every other dose)	½ (or 1 every other dose)	1
Cryoprecipitate	Order prn (dose – 1 unit)	Order prn (dose = 5 pooled units)	Order prn (dose = 10 pooled units)

## Documentation:

- A. Document all assessments / interventions on electronic / unit specific flow sheet.
- B. Document all teaching on electronic / paper multidisciplinary patient teaching record.

## References:

1. AABB. *AABB technical manual*. 19th ed. Bethesda, MA: AABB; 2017.
2. Massive transfusion in trauma guidelines. American College of Surgeons Web site. <https://www.facs.org/~media/files/quality%20programs/trauma/tqip/massive%20transfusion%20in%20trauma%20guidelines.ashx>. Accessed 2019.
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4. Holcomb JB, Wade CE, Michalek JE, et al. Increased plasma and platelet to red blood cell ratios improves outcome in 466 massively transfused civilian trauma patients. *Annals of Surgery*. 2008;248(3):447-458.
5. Ketchum L, Hess JR, Hippala S. Indications for early fresh frozen plasma, cryoprecipitate, and platelet transfusion in trauma. *Journal of Trauma*. 2006;60(6):S51-58.
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7. Nunez TC, Voskresensky IV, Dossett LA, Shinall R, Dutton WD, Cotton, BA. Early prediction of massive transfusion in trauma: Simple as ABC (assessment of blood consumption)? *Journal of Trauma*. 2009;66(2): 346-352.
8. Reiss RF. Hemostatic defects in massive transfusion: rapid diagnosis and management. *American Journal of Critical Care*. 2000;9(3):158-165.
9. Spahn DR, Rossaint R. Coagulopathy and blood component transfusion in trauma. *British Journal of Anaesthesia*. 2005;95(2):130-139.
10. Indiana University Health Riley Hospital for Children. Pediatric massive blood product transfusion protocol. Indianapolis, IN. Published 2012.
11. Barker ME. 0.9% saline induced hyperchloremic acidosis. *Journal of Trauma Nursing*. 2015;22(2):111-116.
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## Bibliography:

Alverno Clinical Laboratory Protocol, Blood Bank Patient Identification.

Franciscan Health Central Indiana Nursing Guideline, Acute Bleeding.

Franciscan Health Central Indiana Nursing Protocol, Obstetric Hemorrhage.

## Review Panel:

Boosey, Melanie, BSN, RNC-OB, Manager, Labor & Delivery, Indianapolis Campus, - 03/2019.

Brock, Stephanie BSN, RNC-OB, NE-BC, Manager, Cherished Beginnings, Mooresville Campus, - 03/2019.

Brown, Stephen, MD, Anesthesiologist and Blood Conservation Medical Director, - 03/2019.

Claborn, Christine, MSN, RN, CEN, TCRN, Trauma Program Manager, Indianapolis Campus, - 03/2019.

Marshall, Ann, MD, Blood Bank / Laboratory Director, - 03/2019.

Dickerson, Stacy, BS, MT(ASCP), Blood Bank MT Coordinator, - 03/2019.

Hiles, A. Katie, Pharm.D, BCPS, Emergency Medicine Clinical Pharmacy Specialist, Indianapolis Campus, - 03/2019.

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Hunt, Karen, MSN, RN, CCRN, Manager, Adult Intensive Care Unit, Indianapolis Campus, - 03/2019.

Lavender, Julie, BSN, RN, CCRN, Manager, Intensive Care Unit, Mooresville Campus, - 03/2019.

Lowder, Nathan, BSN, RN, CEN, NE-BC, EMT, Manager Emergency Department, Mooresville Campus, - 03/2019.

Lyzak, Judy, M.D. M.B.A., Vice President Medical Affairs, Alverno Laboratories, - 03/2019.

Naessens, Jennifer, MSN, RN, NE-BC, Manager Postpartum and Newborn Nursery, Indianapolis Campus, - 03/2019.

Schuessler, Debra, BSN, RN, Clinical Manager, Emergency Department, Indianapolis Campus, - 03/2019.

Wolverton, Cheryl, PhD, RN, CCRN, NEA-BC, Indianapolis Director Critical Care, Indianapolis Campus, - 03/2019.

## Committee Approvals:

Blood Transfusion Committee: - 03/2019.

Clinical Practice Council: - 05/14/2019.

Nursing Executive Council: - 05/2019.

Medical Executive Committee, Indianapolis Campus: - 06/20/2019.

Medical Executive Committee, Mooresville Campus: - 06/12/2019.

Central Indiana Board of Directors: - 06/25/2019.

*If this policy does not yet have an electronic signature, please refer to the policy archives for a signed PDF version.*

## Attachments:

### Approval Signatures

Step Description	Approver	Date
	Agnes Therady: VP CNO	7/5/2019
	Stephanie Heckman: Clinical Nurse Specialist	6/20/2019
Clinical Practice Council	Lisa Hayden: Secretary II	6/17/2019
	Melissa Lowder: Clinical Nurse Specialist	5/31/2019

**Step Description**

**Approver**

**Date**

**Applicability**

Franciscan Health Indianapolis, Franciscan Health Mooresville

# Laboratory Services

**Laboratory services:** There must be laboratory services available twenty-four (24) hours per day. This should include at a minimum blood typing, cross-matching, analyses of blood, urine, and other body fluids, including microsampling when appropriate. There should be capability for coagulation studies, blood gases, and microbiology.

a. **Documentation required:**

- i. Guideline/policy that outlines what services are available 24/7.

Evidence:

- i. Guideline: Laboratory Services Plan for the Provision of Patient Care
  - a. Including what tests are available as STAT

Current Status: Active

PolicyStat ID: 5846892



Origination: 2/7/2017  
Effective: 1/10/2019  
Approved: 1/10/2019  
Last Revised: 2/7/2017  
Expires: 1/10/2020  
Owner: Dobra Bernor  
Policy Area: General Lab  
References:  
Applicability: Alverno Franciscan Health  
Indianapolis  
Alverno Franciscan Health Carmel  
Alverno Franciscan Health  
Mooresville

## Laboratory Services Plan for the Provision of Patient Care

Section:

Document Type: Procedure

### PURPOSE:

The Laboratory Department is an integral part of the hospital organization and exists for the purpose of promoting professional laboratory practice and working toward the common goal of providing a laboratory service based on the highest standards achievable both in service to patients and in employee achievement and satisfaction. Laboratory service is provided to patients in all departments, services and areas of the hospital. The Laboratory will maintain sufficient staffing to meet the needs of the patients in the hospital. All policies and procedures used in the Clinical Laboratory comply with the Accreditation Standards of the College of American Pathologists, HFAP, AABB, CMS and with applicable state and local laws and regulations.

### PROCEDURE:

- A. Scope of Service: The laboratory, at Carmel, Indianapolis and Mooresville, performs diagnostic testing to provide scientifically accurate diagnostic data as requested by the Medical Staff to assist in the diagnosis and treatment of patient illness. The laboratory supports all hospital inpatient and outpatients in all departments and areas of the hospital. The Laboratory maintains a blood transfusion service in order to supply blood and blood components for hospital inpatients and outpatients as required for the patient population that each campus serves. In addition the laboratory at Indianapolis supplies blood products and laboratory testing for an external transitional care hospital. The patient population served includes newborns, children, adolescents, adults and geriatric patients. The patient mix includes inpatients, outpatients, emergency department patients (IN,MV) and clinic patients. The test menu is varied and set for each campus to aid the physician in the diagnosis and treatment of patients. This scope of Service is for the following laboratory areas at Carmel, Indianapolis and Mooresville Campuses.

Area	Campus
Blood Bank	CM,IN,MV
Chemistry/Immunology	CM,IN,MV
Histology/Cytology/Pathology	IN,MV
Microbiology	IN
Phlebotomy (Including Outpatient)	IN,MV,CM
Office/Transcription	IN
Specimen Receiving	CM,IN,MV

This plan does not include the HLA or Stem Cell Lab or Point of Care Testing.

- B. Stat collection and testing is available 24 hours per day, 7 days per week at Indianapolis and Mooresville. Carmel has Stat collection 24/7 performed by nursing when inpatients are present. Stat testing is provided by the lab at Carmel which is staffed from 0600-1900 M-F (Call schedule is used to staff from 1900-0600 and on weekends if inpatient census dictates coverage in the laboratory or via transport of specimens to the Indianapolis campus for testing).

- C. Laboratory hours

1. Collection

- a. Outpatient draw site at Mooresville

- i. The Outpatient Center is staffed at Mooresville Monday-Friday from 06:00 A.M. until 5:30 P.M. and Saturday from 07:00 A.M. until 12:00 P.M. Closed Sundays and Holidays - However collections are available 24 hours per day (registered in ER and drawn by lab staff)
- ii.
- b. Outpatient draw site at Indianapolis
  - i. The Outpatient Center is staffed at Indianapolis Monday-Friday from 06:00 A.M. until 19:00 P.M. and Saturday from 07:00 A.M. until 13:00 P.M. Closed Sunday and Holidays - However collections are available 24 hours per day (registered in ER and drawn by Inpatient phlebotomy staff)
- c. Inpatient - Indianapolis/Mooresville
  - i. Laboratory is open for patient testing 24 hours per day, every day of the year.
  - ii. Routine tests are batched by computer for am draw with initial daily collection at approximately 0300 and approximately every hour thereafter.
  - iii. Timed requests are collected at the time indicated.
  - iv. Urgent requests are add on tests. Lab staff are to check for acceptable specimen in lab prior to collecting. If collection is needed they are drawn ASAP
  - v. Stat requests are collected within 20 minutes of order.
- d. Outpatient draw site at Carmel
  - i. The Outpatient Center is staffed Monday-Friday from 06:00 A.M. until 4:30 P.M.
  - ii. The Outpatient Center is closed on the weekends and holidays
  - iii. Outpatients presenting to Carmel for specimen collection when the Outpatient draw site is closed can present to Indianapolis or Mooresville if Stat services are required.
- e. Inpatient - Carmel
  - i. The inpatients at Carmel are drawn by Nursing
2. Testing
  - a. Indianapolis/Mooresville/Carmel
    - i. Inpatient/ER
      - a. Stat requests are processed immediately with results available within 60 minutes of receipt except where noted on Test Menu. See attachment for STAT list.
      - b. Routine requests are processed as received and should be resultd within 4 hours of receipt unless noted as batched on the Test Menu.
    - ii. Outpatient
      - a. Stat requests are processed immediately with results available within 60 minutes of receipt except where noted on Test Menu. See attachment for STAT list.
      - b. Routine requests are processed and should be resultd within 4 hours of receipt unless noted as batched on the Test Menu.
3. All laboratory tests must be accompanied with a computer order at the request of an authorized person. If entry of test into the computer is not possible, a manual order must be provided. As time permits the manual orders must be entered into the computer.
4. Testing not performed on site
  - a. Tests not performed on Mooresville or Carmel campus that are performed at Indianapolis are sent via courier to Indianapolis and testing is then performed per Indianapolis Turnaround times once received.
  - b. Tests not performed as described above are defined as send out tests that are sent via couriers to Reference Laboratories approved by the Medical Director and MECs of the hospitals. Hospital Staff and Physicians can review send out test requirements and TAT via the on-line test database.
5. Delays in testing
  - a. In the event of an instrument malfunction which prevents the timely reporting of routine laboratory testing, the laboratory will call the patient care unit involved and inform them of the situation.

- b. An estimate of the expected delay will be provided so that alternate testing plans can be initiated (i.e. sending the testing to the other Campus) if the delay in testing will compromise patient care.
  - c. All notifications of testing delays will be documented appropriately. In the event testing will be delayed, the lab staff will notify nursing or physicians per policy.
6. Reporting - All test results are reported through the hospital computer system after verification by qualified laboratory personnel and delivered electronically via the hospital computer system or IHE for non staff physicians. Appropriate records of test results are maintained by the Laboratory. A quality control program is in effect in each area to ensure the accuracy and precision of the test results.
- D. Staffing Plan - The volume of work generated for the patients served dictates that Staffing Plans for patient care services are developed based on the level and scope of care provided and a determination of the skill mix and competency level of personnel that can most appropriately meet the needs of the patients at each campus. Each laboratory area has a staffing plan that is reviewed annually at budget time. This review takes into consideration the following factors: employee turnover, historical trends, benchmarking information, changes in the delivery of care model, changes in the standards of practice, performance assessment, performance improvement activities, patient satisfaction surveys, employee satisfaction surveys and changes in the customer needs/expectations. The staffing patterns will also be evaluated periodically during the year to determine if the workload dictates changes to staffing levels. If necessary, the hours will be adjusted to serve the needs of the patients. Staff Ready is used to define daily staffing needs and shifts to be filled. These staffing plans are developed to provide adequate numbers and mix of staff to meet the needs of testing volume and type of service required to meet patient care.
1. To provide the necessary services for the hospital, the minimum staffing requirement for the lab is as follows:
    - a. Additional staff will be added should staffing levels fall below the minimum requirement and are resolved according to the following. The laboratory utilizes rotating staff to maintain required staffing levels and will move staff around as needed in staffing shortages
      - i. Staffing shortages:
        - PRN staff
        - Part Time off-duty staff
        - Off-duty staff from another shift
        - Assigned overtime
        - On Call will be used if needed to cover when patients are present at Carmel as described above.
        - Temporary staffing may be requested to supplement during staffing shortages.
      - i. Staffing overages:
        - Low Census Overtime Staff
        - Low Census PRN Staff
        - Low Census regular staff on a rotating basis.
    - b. In situations of unusual circumstances (i.e. blizzard), staffing will be determined based on the situation as well as acuity, census, and activity that may be below minimum staffing listed below.

2. Minimum Staffing Grid

POSITION	TECH	MON - FRI		Mon - Fri Lab Asst	TECH	SAT - SUN		Sat - Sun Lab Asst
		PHLEB	Spec Processing			PHLEB	Spec Processing	
Indianapolis Day	6	3	1	1	6	3	1	NA
Indianapolis Evening	4	2	1	1	3	2	1	NA
Indianapolis Midnight	3	2	1	NA	3	2	1	NA
IN Micro Day	2	NA	1	NA	1	NA	1	NA
IN Micro Evening	NA	NA	NA	NA	NA	NA	NA	NA
IN Micro	1	NA	1	NA	1	NA	1	NA

Midnight									
IN Histo Day	1-Cytotech 2-Histotech	NA		1-Histo Asst. 2 - Transcriptionist	NA	NA	NA	NA	NA
IN Histo Evening	NA	NA		NA	NA	NA	NA	NA	NA
IN Histo Midnight	1-Histotech (M-Thur)	NA		NA	NA	1- Histotech (Sun)	NA	NA	NA
Mooreville Day	3	2		1	NA	1	1	1	NA
Mooreville Evening	1	1		1	NA	1	NA	1	NA
Mooreville Midnight	1	NA		1	NA	1	NA	1	NA
Carmel Day	1	NA		NA	NA	On Call when needed	NA	NA	NA
Carmel Evening	1	NA		NA	NA	On Call when needed	NA	NA	NA
Carmel Midnight	On Call when needed	NA		NA	NA	On Call when needed	NA	NA	NA
Indianapolis Outpatient Draw Site	NA	3		3	NA	NA	1	NA	NA
Mooreville Outpatient Draw Site	NA	Same Staff as Inpatient		NA	NA	NA	Same Staff as Inpatient	NA	NA
Carmel Draw Site	NA	1		NA	NA	NA	NA	NA	NA
IHP	NA	1		NA	NA	NA	NA	NA	NA
FSC	NA	NA		NA	NA	NA	NA (would close and direct to OP draw site)	NA	NA

#### E. Test Menu

1. Testing performed at each Campus is documented in the attachment to this procedure. It lists which campus performs the testing on site and the turnaround time (TAT) for the testing to be completed and results available once the specimen is received in the testing laboratory. Testing not performed on site at Mooreville or Carmel but performed at the Indianapolis Campus will be sent to Indianapolis via courier and performed as requested with the TAT listed for that site once the specimen is received at Indianapolis.

#### F. Staffing Mix/ Qualifications

1. Type and mix of staff required to provide services the Laboratory utilizes Medical Technologists, Clinical Lab Scientists, Clinical Laboratory Technicians, Phlebotomists, Specimen Processors, Lab Assistants and other support staff. The Laboratory Director administratively directs the departments. There is a manager who also oversees the Indianapolis, Mooreville and Carmel Campuses along with Supervisors who oversee the day to day operations. MT Coordinators work with the Supervisors and provide technical oversight and support of their respective areas at all three campuses. Quality Managers are assigned to the Laboratory by the Healthcare Quality Department to provide

expertise in Performance Improvement Activities. A Pathologist serves as the Medical Director for the department, acting as a physician liaison between the Laboratory and the other medical specialties within the hospital, and providing input into departmental operations.

2. The Laboratory Medical Director reviews the qualifications of all staff performing testing and documents the level of testing which they qualify for.
3. See attached job descriptions for staff requirements

**G. Quality Goals/Scorecard (Dashboard)**

1. Metrics to be measured and the benchmark are determined each year based on needs of our patient populations and as required by our accreditation agencies. Standard metrics are determined by our laboratory organization. Each facility then may add additional metrics to meet site specific requirements. Refer to the Scorecard for metrics being monitored and benchmarks.
2. The Scorecard is presented to the hospital quality department as well as the laboratory quality committee.

**Attachments:**

Camel On Call Process  
Job Descriptions Management  
Job Descriptions Support Services  
Job Descriptions Technical Staff  
Test Menu

**Approval Signatures**

Approver	Date
Dr. Ann Marshall: Medical Director	1/10/2019
Debra Bernier	1/9/2019

**Applicability**

Alverno Franciscan Health Carmel, Alverno Franciscan Health Indianapolis, Alverno Franciscan Health Mooresville

STATC  
\* IND \*

Franciscan Health	Clinical Laboratory Testing Menu	Campus	Available	Campus	Available	Campus	Available
Indianapolis, Mooresville, Carmel							
Lab Area	ORDERABLE TESTS						
Chemistry/Immunology	Test Name	IN	Stat/TAT	MO	Stat/TAT	CA	Stat/TAT
	Acetone	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Albumin, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Alkaline phosphatase, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	ALT, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Ammonia	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Amylase, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	AST, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Bilirubin, total, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Bilirubin, Direct	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	C-reactive protein, qual and/or quant	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Calcium, ionized, whole blood, non-waived	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Calcium, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Chloride, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Chloride, urine	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Cholesterol, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	CK-MB, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	CO2, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Creatine kinase (CK), serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Creatinine, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Creatinine, urine, quantitative	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	GGT, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Glucose, CSF	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Glucose, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	hCG, qualitative, serum	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	hCG, quantitative, serum	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	hCG, urine, waived	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	HDL cholesterol, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Iron, serum	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Lactate, plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	LD, serum	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Lipase, serum	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Lithium, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Magnesium, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Osmolality, serum/plasma/whole blood, measured	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Osmolality, urine	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Phosphorus, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Potassium, serum/plasma	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Potassium, urine	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Protein, total, CSF	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Protein, total, quantitative, urine	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
	Protein, total, serum	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN

\* \*

\* STATC JDA \*

Sodium, serum/plasma		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Sodium, urine		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Triglycerides, serum/plasma		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Troponin I		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Urea, serum/plasma		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Uric acid, serum		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
D-dimer, quantitative		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
C. difficile detection (non-molecular)		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Cryptococcal antigen		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Infectious mononucleosis, non-waived		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Influenza antigen, non-DFA method, waived		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
RSV antigen, non-DFA method, waived		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Strep A rapid antigen, waived		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Acetaminophen		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
AFP & PP12, rapid, amniotic fluid		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Amikacin, serum		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
BNP		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Carbamazepine		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Cortisol, serum/plasma		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Cyclosporine, whole blood		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Digoxin		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Esradial		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Fetal fibronectin		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Follicle stimulating hormone (FSH)		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Gentamicin, serum		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
HIV-1/2 antibody/p24 antigen, rapid test, non-waived		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Luteinizing hormone (LH)		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Meloxicam, serum		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Parathyroid hormone (PTH), serum - Intact		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Parathyroid hormone (PTH), serum - Intraoperative Only		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Phenobarbital		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Phenytoin		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Procalcitonin		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Progesterone, serum/plasma		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Salicylate		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
T4, free		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
T4, total		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Theophylline		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Tobramycin, serum		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
TSH, serum		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Valproic acid		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Vancomycin, serum		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Alcohol/volatiles, serum, medical		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Urine toxicology, qual. automated immunoassay		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN
Body fluid cell count		Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN	Y	Y/60MIN

\* \*

		T	Y	Y/60MIN	Y	Y/60MIN	
Body fluid differential/cell identification							
Crystal identification or pres/abs, body fluid		Y					
Anthrithrombin III		Y					
Heparin Xa		Y					
Fibrinogen		Y	Y/2HR				
Platelet function assay (PFA)		Y	Y/60MIN				
Platelet function, rapid, aspirin		Y					
Platelet function, rapid, P2Y12 inhibition		Y					
PT, plasma (INR)		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
PTT, plasma		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
Bone marrow collection (assist)		Y					
Bone marrow stain (Wright/Giemsa), Hematology		Y					
Eosinophil count		Y	Y/60MIN		Y	Y/60MIN	
Eosinophils, nasal smear		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
ESR		Y					
Fecal leukocytes, stain other than giemsa		Y			Y	Y/60MIN	Y/60MIN
Hematocrit		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
Hemoglobin		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
Kleihauer-Betke stain (fetal cell quantitation)		Y	Y/60MIN				
Platelet count		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
RBC count		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
Reticulocyte count, automated		Y	Y/60MIN				
Sickling test, hemoglobin solubility		Y	Y/2HR				
WBC count		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
WBC differential		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
Eosinophils, urine		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
Urinalysis dipstick		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
Urinalysis microscopic		Y	Y/60MIN		Y	Y/60MIN	Y/60MIN
Microbiology							
Bacterial Culture, anaerobic/aerobic		Y					
GC Culture		Y					
Throat Culture		Y					
Urine Culture		Y					
Blood cultures		Y					
Gram stain		Y	Y/60MIN		Y	Y/60MIN	
Joint Fluid Crystals		Y					
Occult blood, fecal		Y	Y/60MIN		Y	Y/60MIN	
Stool Culture		Y					
Vaginal wet mount, Trichomonas only		Y	Y/60MIN		Y	Y/60MIN	
Gastrocult		Y	Y/60MIN				
Fungal Culture		Y					
KOH prep (e.g., skin, hair, nail, vaginal)		Y					
O & P Screen		Y	Y/60MIN		Y	Y/60MIN	
Pintworm prep		Y					
Respiratory Culture (other than throat)		Y					

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# Post Anesthesia Care Unit (PACU)

**Post-anesthesia care unit:** The post-anesthesia care unit (PACU) must have qualified nurses and necessary equipment twenty-four (24) hours per day.

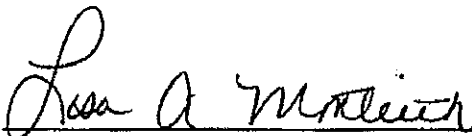
- a. **Documentation required:**
  - i. Include a list of available equipment in the PACU.

Evidence:

- i. Available equipment in PACU

**Post Anesthesia Care Unit (PACU) Equipment****Essential equipment per *Resources for the Optimal Care of the Injured Patient***

1. Pulse Oximetry
  - a. Each patient station has a dedicated pulse oximeter
2. End-tidal CO<sub>2</sub> detection
  - a. Each patient station has a dedicated pulse oximeter
3. Arterial pressure monitoring
  - a. Each station has arterial pressure monitoring capabilities
4. Pulmonary artery catheterization
  - a. One station that can monitor both arterial pressure and pulmonary arterial pressure.
  - b. 14 stations that can monitor either arterial or pulmonary pressure.
5. Patient rewarming
  - a. 5 portable Bair huggers in PACU
6. Intracranial pressure monitoring
  - a. 0 Camino monitors in PACU - Camino monitors are housed in ICU.

  
\_\_\_\_\_  
PACU Manager

12/5/19  
Date

NOVEMBER 5  
11:00 AM - 12:00 PM  
12:00 PM - 1:00 PM  
1:00 PM - 2:00 PM

MOORESVILLE  
11:00 AM - 12:00 PM  
12:00 PM - 1:00 PM  
1:00 PM - 2:00 PM

CARME  
11:00 AM - 12:00 PM  
12:00 PM - 1:00 PM  
1:00 PM - 2:00 PM

# Organ Procurement Organization

**Relationship with an organ procurement organization (OPO):** There must be written evidence that the hospital has an established relationship with a recognized OPO. There must also be written policies for triggering of notification of the OPO.

a. **Documentation required:**

- i. Written policy regarding OPO participation in the trauma program and triggers for notifying OPO.

**Evidence:**

- i. Policy: Anatomical Gift/Organ Donation Policy
  - a. Includes Indiana Donor Network Donation Statistics

Current Status: Active

PolicyStat ID: 3284473



**Franciscan**  
**ALLIANCE**

Original: 10/25/1984  
Last Reviewed: 3/29/2017  
Last Revised: 3/29/2017  
Next Review: 3/28/2020  
Responsible Party: Melissa Lowder: Clinical  
Nurse Specialist  
Policy Area: Nursing  
References: Policy  
Applicability: Franciscan Health  
Indianapolis  
Franciscan Health  
Indianapolis at Carmel  
Franciscan Health  
Mooresville

## Anatomical Gift / Organ Donation Policy

9/12/16 Franciscan Alliance hospital facility names were changed. See Hospital Listing document for new name changes and previous names.

Number: 400.04

Section: General

Keywords:

Organ Donation, IOPO, DCD, cardiac, death, circulatory, OPO, IDN, Indiana Donor Network

### Purpose:

The policy outlines the steps taken at time of death, or impending cardiac death, to provide the opportunity for donation of organs, tissues and eyes.

This policy addresses HFAP Standard Elements:

14.00.00 (Condition of Participation: Organ, Tissue and Eye Procurement)

14.00.01 (Organ/Tissue Donation and Transplantation)

In compliance with the Centers for Medicare and Medicaid programs, 42 CFR Part 482, Hospital Condition of Participation, Section 1138 of the Social Security Act, USC 1329b-8, the Indiana Anatomical Gift Act, IC 29-2-16-2, and the Franciscan Alliance Corporate Policy, Organ Donation After Circulatory Death (DCD), # 200.03. The organization shall ensure, in collaboration with the Indiana Donor Network, that the family of each potential donor, or person legally responsible for a potential donor, is informed of the option to donate organs, tissue and eyes, or to decline to donate. This policy upholds the Ethical and Religious Directives for Catholic Health Care Services by providing a protocol to offer patients and / or families the right to choose organ donation when organ donation after cardiac death criteria is met, but when neurological criteria for death has not been met. The Indiana Donor Network and the organization shall encourage discretion and sensitivity with respect to the circumstances, views and beliefs of potential donor patients and the families of potential donors.

## Scope:

All Patient Care Areas

## Responsible Persons:

RN, LPN, Health Unit Coordinator (HUC), Patient Care Assistant (PCA) and Patient Care Novice (PCN)

## Equipment:

Authorization for Donation of Organs / Tissues / Eyes – provided by the Indiana Donor Network

Electronic / Manual Lab Requisitions

Patient labels

Electronic / Unit Specific Flowsheet

Notice of Death electronic form (Paper form: Franciscan Health Indianapolis, Mooresville, Carmel Form # 205-605)

## Definitions:

**Brain Death** - Irreversible cessation of cerebral and brain stem function; characterized by absence of electrical activity in the brain, blood flow to the brain, and brain function as determined by clinical assessment of responses. A brain dead person is considered dead, although his or her cardiopulmonary functioning may be artificially maintained for some time.

**Donation after Cardiac Death (DCD)** - Recovery of organs and / or tissues from a donor whose heart has irreversibly stopped beating, previously referred to as a non-heart-beating or asystolic donation.

**Donation after Brain Death** - Recovery of organs and / or tissues from a donor who has been pronounced brain dead.

## Procedure:

### A. Administrative Directives:

1. The Indiana Donor Network is the only Franciscan Health Indianapolis, Mooresville, Camel designated requestor of patient's potential candidacy for organ donation.
2. The Indiana Donor Network will be notified by the nurse, HUC or physician / allied health professional:
  - a. Of all deaths, including that of a patient who has made a prior request or arrangement to donate his/her remains for the purposes of scientific research.
  - b. Prior to any patient being terminally weaned from life support (i.e. mechanical ventilator, vaso-pressor medications, etc.) with a diagnosis of brain death or severe brain injury. **The Indiana Donor Network must be contacted within one (1) hour before initiation of the weaning process.**
  - c. Of any patient with a Glasgow coma score of five (5) or less regardless of sedation (call within one (1) hour) or loss of two (2) neurological functions.
  - d. The computer application will fire a Best Practice Alert (BPA) and alert the nurse of patients with a GCS of 5 or less which will direct the nurse to notify the Indiana Donor Network. The BPA will

refire and alert the nurse every four (4) hours until acknowledged.

3. The Indiana Donor Network will be notified by the nurse, HUC or physician / allied health professional of appropriate candidates for DCD, including:

- a. A patient with a non-recoverable illness that has caused severe neurological devastation and / or illness or injury resulting in ventilator dependency.
- b. A decision has been made to invoke the surrogate act, a Do Not Resuscitate (DNR) order, and withdraw life support.
- c. The patient is expected to arrest within one hour of extubation based on the opinion of the hospital's healthcare team.
- d. The patient has irreversible cessation of blood circulation and respiratory function.

4. The organization will work cooperatively with the Indiana Donor Network in reviewing death records to improve identification of potential donors and educating staff on donation issues.

5. Spiritual Care Department and / or Palliative Medicine will be informed of the potential donor situation by the nursing unit in order to be available to offer spiritual / emotional support to family and staff.

**B. Communication to the Indiana Donor Network:**

- 1. Communication to the Indiana Donor Network will be made using the criteria listed above.
- 2. The Indiana Donor Network representative will contact the hospital for further screening.
- 3. An entry will be made in the electronic notice of death form in the organ / tissue donation section of the electronic record, noting the date and time of the Indiana Donor Network notification, the Indiana Donor Network representatives name and the electronic signature of the person making the call.
- 4. A brief description of the outcome of the call will be documented on the paper icon of the electronic flowsheet row on the notice of death electronic flowsheet.
- 5. If the patient is terminally weaned and does not expire prior to hospital discharge the electronic Notice of Death form information will be a legal part of the medical record.
- 6. If patient was determined not to be a candidate for donation and the patient is terminally weaned and expires during the hospitalization a second telephone call to the Indiana Donor Network is required to notify the Indiana Donor Network of the actual death.
- 7. Document second call to the Indiana Donor Network with appropriate information of the patient's death on the electronic Notice of Death form.

**C. Obtaining Consent for Donation (Designated Requestor):**

- 1. An Indiana Donor Network representative will determine the patient's potential candidacy for organ donation.
- 2. Upon affirmation of a patient's status as a potential donor, the "representative" of the patient will be informed of the option to donate or to decline to donate.
- 3. Under Indiana's Uniform Anatomical Gift Act (UAGA), Indiana Code IC 29-2-16.1 if a person is medically suitable for donation and knowledge of the donors' declaration of an anatomical gift is known, Indiana law considers this declaration authorization to proceed with donation. Evidence of a declaration of gift may include, but not be limited to a government issued driver's license or identification card or, through documentation from an appropriate anatomical gift registry. A driver's license that is suspended, revoked or expired does not change the validity of the declaration of gift.

Upon determination by the Organ Procurement Organization that a declaration of gift is valid, no further approval is required from the patient, patient's next of kin, agent or POA in order to proceed with the donation of organs and / or tissue.

4. If there is a conflict or disagreement from the patient's representatives with the above the Chief Medical Officer (CMO) or his / her designee will meet with the patient's representatives to inform them of the Indiana law and provide support and offering of spiritual care. CMO will notify appropriate hospital administration of conflict. Donation process will proceed in accordance with Indiana law.
5. If no declaration has been made, or the patient is a minor, then consent must be obtained by the appropriate next-of-kin.
6. The "representative" to give consent is any of the following classes of persons who are reasonably available in the order of the priority, based upon the Indiana Code IC 29-2-16-2 Uniform Anatomical Gift Act (UAGA) as stated:
  - a. An agent of the decedent at the time of death who could have made an anatomical gift under section 3(2) of the UAGA immediately before the decedent's death;
  - b. The spouse of the decedent;
  - c. Adult children of the decedent;
  - d. Parents of the decedent;
  - e. Adult siblings of the decedent;
  - f. Adult grandchildren of the decedent;
  - g. Grandparents of the decedent;
  - h. An adult who exhibited special care and concern for the decedent;
    - i. A person acting as the guardian of the decedent at the time of death;
    - j. Any other person having the authority to dispose of the decedent's body;
7. If there is more than one member of class entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to whom the gift may be passed under section 10 of the UAGA knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.
8. Should consent for donation be given, the Indiana Donor Network coordinator will:
  - a. Complete the consent form (Anatomical Gift By Person Other Than Living Donor).
  - b. Conduct and document a thorough medical / behavioral history interview.
  - c. Contact the Coroner (if indicated) to obtain permission to proceed with donation.
  - d. Provide the family time to spend with the body.
  - e. Notify the appropriate nursing staff of the donor / procurement status.
9. Should consent for donation be declined, the Indiana Donor Network coordinator will:
  - a. Support the family's decision
  - b. Document in the patient's medical record on paper progress notes the decision not to donate, if on site. If the Indiana Donor Network is not on site, nursing will complete the electronic Notice of Death form as indicated.

#### **D. Nursing / Hospital Responsibilities at Time of Death:**

1. The nurse, HUC or physician / allied health professional will notify the Indiana Donor Network of all patient deaths as outlined in the Administrative Directive section of this policy. The Indiana Donor Network is to be contacted by telephone at 1-800-356-7757.
2. The body is to remain in the hospital until donation determination has been made. The body must not be released to a funeral home until donation status has been determined.
  - a. For patients that are already deceased, transfer the body to the morgue.
  - b. For patient's that are brain dead, the body is to remain in the room until procurement.
  - c. For DCD patient's, the patient is to remain in the room until they are taken to operating room. If the patient does not expire in the operating room, then the patient is either returned to the same bed or transferred to another bed (see F.6.c.v. below).
3. Notify the Nursing Supervisor if the body has been moved to the morgue.
4. If consent for donation is obtained, notify the Admitting Department using two (2) patient specific identifiers, and the time the consent form was signed by the legal representative of the patient. Advise the Admitting Department that there will be a delay in bed availability due to the procurement preparation and procedure. Refer to Patient Access Policy, Organ Procurement Policy.
5. Globe enucleation and in-situ corneal incision for eye tissue donation may be performed in the operating room, patient room and / or morgue.
  - **Special Note:** In Labor & Delivery, after procurement of eye tissue, the body of the infant may be returned to the unit / room to allow family time with the infant.
6. the Indiana Donor Network assumes all costs incurred with the procurement.
7. Complete the electronic "Notice of Death" form in Epic when death is determined. The "organ / tissue / eye donation" section of the electronic form is to be completed by the primary nurse responsible for the patient.

#### **E. Nursing / Hospital Responsibilities Regarding Procurement:**

1. Neither the attending physician at the time of death nor the one who certifies the death may participate in the organ procurement unless specifically authorized in writing by the decedent.
2. For brain dead donor's, orders for treatments and interventions may be taken from an Indiana Donor Network representative. For DCD donors, the attending physician / allied health professional will continue to aggressively treat / support the patient. The Indiana Donor Network representative must write his or her own orders and they must be under the direction of the Indiana Donor Network medical director.
3. The hospital barcode medication administration processes will be utilized throughout the procurement process for all medication that come from the hospital pharmacy.
4. The patient's assessment parameters will be performed and documented per unit policy in the electronic documentation system (or unit specific flowsheet if electronic documentation not available in department). All other documentation will be on the Indiana Donor Network specific flowsheet.
5. Communicate with the Operating Room Control Desk regarding scheduled time of procurement procedure.
  - a. At Mooresville Campus during the night and weekends, call the on-call operating staff / team.

6. The Indiana Donor Network may determine the patient is acceptable to be transferred to the Indiana Donor Network facility for organ / tissue procurement. The Indiana Donor Network must seek consent from the legal patient representative to transfer the patient. If the patient is to be transferred there will be no utilization of the Franciscan Health OR facilities.
7. Notify the nursing unit manager or the nursing supervisor when the procurement team has arrived.
8. Notify the Admitting Department of bed status and availability once the body has been moved

**F. Organ Donation After Cardiac Death (DCD):**

1. The Indiana Donor Network will be notified of appropriate candidates for DCD as outlined in section A of this policy.
2. Donor Suitability / Referral:
  - a. The attending physician / allied health professional will discuss with the family the decision to withdraw life support. This discussion must be made independent of, separate from, and predating any discussion about organ donation. The family must be able to acknowledge that withdrawal of life support will result in cardiopulmonary arrest and that there will not be any attempt made by the healthcare providers to resuscitate the patient. The family will also acknowledge that the time frame in which cardiopulmonary arrest occurs is unknown.
    - i. The discussion about the option of donation will take place after the decision to remove life support has been made by the family.
    - ii. After the decision has been made by the family and physician / allied health professional to withdraw life support by met criteria, the Indiana Donor Network must be contacted regarding organ / tissue donation prior to initiating terminal wean or changing the code status.
    - iii. The Indiana Donor Network Coordinator, with the full knowledge and assistance of the attending physician / allied health professional, will conduct the following:
      - A review of the hospital medical record including age, diagnostics, labs and medical history.
      - An initial physical assessment.
      - Verification of the documentation of the family discussion and decision to withdraw support.
    - iv. Should the patient be deemed unsuitable for donation, the attending physician / allied health professional will be informed of the rationale for unsuitability and the Indiana Donor Network coordinator will document the rationale for declining the patient for DCD on paper progress notes in the medical record.
3. Consent Process:
  - a. The Indiana Donor Network coordinator will approach the "representative" of the patient (must follow the priority class listed in section C. 6. a-j above) to initiate the consent process. The following information will be provided as part of securing consent:
    - i. Organs and tissues that can be donated.
    - ii. A complete explanation of the DCD process and organ recovery process.
    - iii. The extubation and location of death is expected to be in the operating room suite.

- iv. Organ recovery will take place immediately after the physician / allied health professional has pronounced the death.
- v. At the time of death the family will be escorted out of the OR in order for the procurement to proceed. If the family chooses to view the deceased after organ procurement, arrangements will be made for this to occur outside of the operating room (OR).
- vi. There is no cost to the family for organ evaluation, allocation or recovery.
- vii. In the event that the patient does not expire within sixty (60) minutes after discontinuation of life support and does not demonstrate a significant progression towards death, the organ donation process will cease.
- viii. A signed and witnessed consent form will be obtained and copies will be given to the hospital and the legal next of kin.

4. Family Procedure After Consent:

- a. At the family's request two (2) family members will be allowed to accompany the donor to the operating room (OR).
- b. Prior to entering the operating room (OR), all parties will be required to put on a surgery suit.
- c. The family members will be accompanied by Spiritual Care, Palliative Care, and / or an RN who will remain with the family until time of death.

5. Donor Maintenance:

- a. The responsible physician / allied health professional will retain full responsibility for the patient until such time as the patient's death is pronounced. The responsible physician / allied health professional for the patient will make a clinical judgment of the advisability of administering medications for comfort measures.
- b. The patient must remain hemodynamically supported for organ perfusion prior to withdrawal of life support
- c. The administration of clinically appropriate medications in appropriate doses to provide comfort is acceptable and encouraged.
- d. The use of paralytics is prohibited.
- e. Interventions to preserve organ function but which may cause patient discomfort or hasten death are prohibited.

6. Withdrawal of Life Support:

- a. Withdrawal of life support will only occur in the operating room suite. OR staff will cover windows of the OR room prior to patient being brought to the room. Monitor leads are to be placed onto the patient's back. The organ recovery team will not be present during the withdrawal of support or during the certification of death, but must be in the hospital and available prior to withdrawing support.
- b. Cardiac monitoring and invasive blood pressure monitoring will be maintained. Under no circumstances shall a member of the OPO team participate in the discontinuation of life support measures.
- c. Donor extubation in the OR:
  - i. The assistance of a scrub nurse and circulator is required. the patient's attending or

disignee also needs to be present.

- ii. The patient is prepped and draped in the usual fashion and the necessary solution and recovery equipment are readily available.
  - iii. "Comfort measures" (i.e. IV morphine) may be used per physician, family request or hospital protocol prior to removal of life support. Heparin may be administered at the time of extubation.
  - iv. The responsible physician / allied health professional or RT will withdraw life support. Following at least five minutes of asystole and / or pulseless electrical activity (PEA) per cardiac monitor, the patient will be pronounced dead by the attending physician or his / her physician designee. The actual recovery of organs then begins.
  - v. If the patient's status does not deteriorate to death within the designated time of sixty (60) minutes and does not demonstrate a significant deterioration towards death, the donation process will cease and comfort measures will be maintained. If cardiac death does not occur, the patient and family will be transported to an inpatient room and admitted under the care of the attending physician / allied health professional for continuation of routine end of life care.
- d. The date and time of death will be in the electronic Notice of Death Record in the patient's hospital record and the physician / allied health professional declaring death will complete the electronic "Pronouncement of Patient Death form.
  - e. With solid organ donation, nursing care is to be maintained and regular documentation continued. The patient is to be transported to surgery with ventilator life support maintained. Documentation of nursing care is to be continued during organ donation process and recorded on forms provided by the Indiana Donor Network. The Indiana Donor Network will include a copy for the hospital permanent record. With solid organ donation, the OR will provide nursing care documentation on the operative record. The Indiana Donor Network will receive a copy for their records.

## Documentation:

- A. Document all assessments / interventions on electronic / unit specific flow sheet.
- B. Document all teaching on electronic / paper multidisciplinary patient teaching record.
- C. Record in Nurses Notes, Electronic / Unit Specific Flow sheet verification of signed consent for organ / tissue / eye donation.
- D. Complete the Notice of Death Form. The form is to accompany the body to the morgue.
- E. The Indiana Donor Network form "Authorization for Donation of Organs / Tissues / Eyes" is to be placed in the permanent medical record.
- F. Telephone notification to the Indiana Donor Network is documented in the electronic Notice of Death form.

## Bibliography:

Centers for Medicare & Medicaid Programs, 42 CFR Part 482. Hospital Condition of Participation, Section 1138.

Franciscan Alliance, Corporate Policy, Organ Donation After Cardiac Death (DCD), # 1112.02.

Anatomical Gift / Organ Donation Policy. Retrieved 11/21/2019. Official copy at <http://fa-stf-indianapolis.policystat.com/policy/3284473/>. Copyright © 2019 Franciscan Health Indianapolis

Franciscan Health, Patient Access Policy, Organ Procurement Policy.

Indiana Uniform Anatomical Gift Act (IUAGA) 29-2-16.1 & IC 29-2-16-2, Social Security Act USG 1329b-8

## Review Panel:

Lowder, Melissa, DNP, RN, ACN-BC, CCRN, Clinical Nurse Specialist, - 02/2017.

Schneider, Barb, RN, Intensive Care Unit, Mooresville Campus, - 02/2017.

Wolverton, Cheryl, MSN, RN, NE-BC, Director of Critical Care, Dialysis, and RT, - 02/2017.

## Committee Approvals:

Clinical Practice Council: - 02/14/2017.

Nursing Executive Committee: - 02/2017.

Medical Executive Committee, Carmel Campus: - 03/21/2017.

Medical Executive Committee, Indianapolis Campus: - 03/16/2017.

Medical Executive Committee, Mooresville Campus: - 03/08/2017.

*If this policy does not yet have an electronic signature, please refer to the policy archives for a signed PDF version.*

## Attachments:

### Approval Signatures

Step Description	Approver	Date
	Susan McRoberts: 851078-VP Patient Care Svcs CNO	3/29/2017
	Stephanie Heckman: 501012-Clinical Nurse Specialist	3/24/2017
Clinical Practice Council	Lisa Hayden: 201165-Secretary II	3/24/2017
	Melissa Lowder: 501012-Clinical Nurse Specialist	3/1/2017

### Applicability

Franciscan Health Indianapolis, Franciscan Health Indianapolis at Carmel, Franciscan Health Mooresville



Franklin Health Indianapolis  
1/1/2019 - 10/31/2019 Donation Statistics and Benchmarks

Organ Donation	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Goal	State Total
Overall Organ Authorization Rate	0.00%	100.00%	100.00%	100.00%	100.00%			0.00%		50.00%			57.14%	80.00%	73.99%
CMS Organ Conversion Rate			100.00%	100.00%						100.00%			100.00%	75.00%	80.66%
BD Authorization Rate	0.00%	100.00%	100.00%										100.00%		84.28%
DCD Authorization Rate				100.00%				0.00%		50.00%			40.00%		53.13%
Total Organ Donors	0	0	0	1	0	0	0	0	0	0	1		3		146
Total BD Donors	0	0	0	1	0	0	0	0	0	0	0		1		121
Total DCD Donors	0	0	0	0	1	0	0	0	0	0	1		2		25
Total BD Declines	0	0	0	0	0	0	0	0	0	0	0		0		25
Total DCD Declines	1	0	0	0	0	0	0	1	0	0	1		3		30
Total No Go Donors	0	1	0	0	0	0	0	0	0	0	0		1		19
Total Coroner Declines	0	0	0	0	0	0	0	0	0	0	0		0		1
Eligible Organ Patients	1	0	1	1	0	0	0	0	1	0	2		6		201
Total Organ Referrals	30	25	35	25	30	26	18	27	24	36			276		5478
Total Missed Organ Referrals	0	0	0	0	0	0	0	0	0	0	0		0		134
Organ Referral Rate	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			100.00%	100.00%	97.61%
Total Late Organ Referrals	0	0	0	0	0	0	0	0	1	0			1		100
Total Organ Unplanned Mentions	0	0	0	0	0	0	0	0	0	0	0		0		10

Tissue Donation	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Goal	State Total
Tissue Authorization Rate	75.00%	58.82%	60.00%	61.11%	65.38%	36.84%	41.67%	25.00%	50.00%	46.15%			52.94%	44.00%	48.52%
Total Tissue Donors	10	9	8	8	12	5	4	3	8	5			72		1692
Total Declines	4	6	6	7	9	13	7	13	9	7			81		2259
Total No Go Donors	2	1	1	3	5	2	1	1	1	1			18		453
Tissue Coroner Declines	0	0	0	0	0	0	0	0	0	0			0		29
Early Release to Funeral Home	0	0	0	0	0	0	0	0	0	0			0		20
Eligible Not Approached	4	1	2	2	1	2	1	2	2	3			20		587
CTOD not called (previous referral)	0	0	0	0	0	0	0	0	0	0			0		4
Eligible Tissue Patients	20	17	17	20	27	22	13	19	20	16			191		5065
Tissue Unplanned Mention	0	0	0	0	0	0	0	0	0	0			0		76
Hospital Deaths															
Total # Hospital Deaths	75	57	60	57	74	56	43	49	51				522		13403
# of Deaths Not Reported	0	0	0	0	0	0	0	1	1				2		34

Andie Bleyle  
Hospital Liaison  
ableyle@indonetwork.org

Number of lives saved	7.00
Estimated # of lives healed	5,400
Organs per Donor	2.33

# Operational Performance Improvement Committee

**Operational process performance improvement committee:** There must be a trauma program operational process performance improvement committee and documentation must include a roster of the committee and meeting times for the previous year. This meeting must occur at least quarterly

a. **Documentation required:**

- i. Signed letter from Trauma Medical Director and Trauma Program Manager outlining committee membership and meeting frequency.
- ii. Complete Operational Attendance spreadsheet provided by ISDH Designation Subcommittee. Include data from most recent twelve (12) months.
- iii. All Trauma Surgeons and all the Liaisons must have attended at least two (2) Operational meetings prior to submission of the application, held no more frequently than monthly

**Evidence:**

- i. Signed letter from TMD and TPM
- ii. Operational Attendance Spreadsheet
- iii. TOPI charter

November 2019

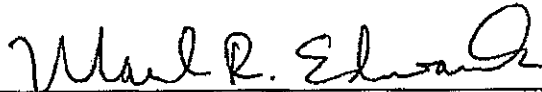
The Trauma Operational Performance Improvement Committee (TOPI) is scheduled monthly on the third Tuesday of the month. Meetings will occur quarterly at minimum.

Physician liaisons from the following areas participate on the committee:

- Trauma Medical Director
- General/Trauma Surgery
- Anesthesia
- Emergency Medicine
- Critical Care/Internal Medicine
- Neurosurgery
- Radiology

Additional support is provided by:

- Trauma Program Manager
- Trauma Registrar
- Director/Manager Emergency Department
- Director/Manager Intensive Care
- Director/Manager Surgical Services
- Quality Coordinators
- Respiratory Therapy
- Blood Bank
- Radiology
- Pharmacy
- Indiana Donor Network
- EMS Liaison



Mark Edwards, MD, FACS, Trauma Medical Director

11/20/19  
Date



Christine Claborn, MSN, RN, CEN, TCRN, Trauma Program Manager

11-2019  
Date

# Franciscan Health Indianapolis Trauma Operations Performance Improvement Committee (TOPI) Attendance

Total Number of Operational Performance Committee meetings held :		3	* = excused per ACS guidelines		1. Please place total number of Operational Process Performance Committee meetings held in B1 field. 2. Place all meeting dates in columns starting in D7, using only the number of columns appropriate for your facility and deleting excess columns. (i.e. if you only had quarterly meetings, then enter dates in C2 through F2) 3. Then list all committee members in column A with their attendance recorded in appropriate columns. 4. The overall attendance will automatically calculate.		
Representing	Last Name	First Name	10/15/2019	11/19/2019	12/17/2019	Overall Attendance	Overall Attendance Percentage
<b>Physicians</b>							
Anesthesia	Henne	Shana			X	1	33.33%
	Terrell	Kurt	X	X		2	66.67%
Emergency Medicine	Hartman	Chris			X	1	33.33%
	(TMD) Edwards	Mark	X	X	X	3	100.00%
General/Trauma Surgery	King	Donald	X	X	X	3	100.00%
	Libke	Mathew		X	X	2	66.67%
	Mandelbaum	Jon			X	1	33.33%
	Murage	Karluk	X	X		2	66.67%
	Seudeal	Kyle		X	X	2	66.67%
	Wanko Mboumi	Igor			X	1	33.33%
	Snyder	Michael	X	X	X	3	100.00%
Internal Medicine/ CCM	Alawneh	Ahmad	X			1	33.33%
	Boone	Linda	X			1	33.33%
Neurosurgery	Spomar	Daniel			X	1	33.33%
Orthopedic Surgery	Laboe	Patrick			X	1	33.33%
Radiologists	Paluszny	Mark	X	X	X	3	100.00%
	Blahunka	James				0	0.00%
<b>Hospital Support</b>							
Administration	Annee	Sharon				0	0.00%
	Ruff	Terri				0	0.00%
Blood Bank	Dickerson	Stacy	X	X	X	3	100.00%
	Corbin	Vince			X	1	33.33%
Emergency Department	Fowler	Brad				0	0.00%
	Frankel	Cindy	X		X	2	66.67%
	Schuessler	Deb			X	1	33.33%
EMS Liaison	Kavanagh	Jon	X	X		2	66.67%
Imaging	Brocker	Christina				0	0.00%
	Mershon	Charisse	X	X		2	66.67%
Indiana Donor Network (AD HOC)	Bleye	Andie			X	1	AD HOC
	Conjelko	Julie			X	1	33.33%
Intensive Care Unit	Wolverton	Cheryl				0	0.00%
	Williams	Allison	X			1	33.33%
Interventional Radiology	McAlister	Ablgall	X			1	33.33%
Nursing Education	Boyce	Michelle				0	0.00%
Operating Rooms	Baker	Stacy		X		1	33.33%
	Bennett	Marci	X	X		1	33.33%
	Piercy	Justin		X		1	33.33%
Perianesthesia Manager	Montelth	Lisa	X	X	X	3	100.00%
Pharmacy	Hiles	Katie		X	X	2	66.67%
	Hentz	Debby	X	X	X	3	100.00%
Quality Coordinators	Knight	Beth		X		1	33.33%
	Little	Connie				0	0.00%
Respiratory Therapy	Lyon	Kathie	X		X	2	66.67%
	Carroll	Michael	X	X	X	3	100.00%
Trauma Administration	(TPM) Claborn	Christy	X	X	X	3	100.00%
	Sorocco	Tyler	X	X	X	3	100.00%

Per 3/9/16 ACS revision document, one pre-determined alternate will be acceptable to attend the peer review in place of the liaison. (pg 15)

\*excused per 11/9/16 ACS revision document, peer review meeting attendance may be waived for deployment, medical leave, and missionary work. The center must provide documentation to support the absence



# Franciscan HEALTH

## TRAUMA SERVICES

### **Trauma Operational Performance Improvement Committee (TOPI) Charter**

#### **Purpose**

The Trauma Operations Performance Improvement Committee (TOPI) is responsible for overseeing injured patient care at Franciscan Health Indianapolis (FHIN). The goal of this committee is to provide a framework for the planning and implementation of performance improvement activities to provide optimal care for all injured patients at the in-process Franciscan Health Indianapolis Level III Trauma Center.

#### **Mission and Vision**

The mission and vision of TOPI align with Franciscan Health's mission and vision.

**Mission:** Franciscan Health Indianapolis will provide comprehensive trauma services in a cost-effective manner with a high degree of measurable quality to the Franciscan Health Indianapolis community.

**Vision:** Leading the way to a healthier community through improved injured patient care and injury prevention activities for individuals across the life spectrum.

#### **Authority and Scope and Integration into Hospital Performance Improvement Process**

Injured patient care crosses many specialty lines. The Franciscan Health Indianapolis Governing Body has committed to the development of a Trauma Operations Performance Improvement Committee (TOPI). The committee is under the direction of the Trauma Medical Director and the Trauma Program Manager as authority has been granted by the FHIN Governing Body. The trauma service has the authority to monitor all events that occur during a trauma-related episode of care while admitted to FHIN. The TOPI committee reports performance improvement (PI) activity to the FHIN Quality Council at least twice a year and the FHIN Patient Safety Committee as needed. Trauma Operations PI reports will be submitted to the Medical Executive Committee and to the Board through the Quality Council.

The Quality Department will assist with the performance improvement activities, peer review, and reporting.

The granting of privileges and credentialing are departmental and medical staff functions and are overseen by the governing board. The Trauma Medical Director has the authority to set the qualification for the trauma service members including individuals in specialties involved with the care of the trauma patient.

The trauma program will undergo appropriate external assessments by the American College of Surgeons (ACS) and Indiana State Department of Health at routine intervals. Team members will

participate in local and regional trauma system performance improvement efforts. Community Relations will assist with promoting the trauma program and trauma injury prevention.

Refer to the Trauma Performance Improvement Plan for further details of Performance Improvement and Patient Safety (PIPS) activities and processes.

### **Membership**

Membership to TOPI is multidisciplinary as trauma care is not limited to one body system. The Trauma Medical Director and Trauma Program Manager will oversee and act as chairs. All trauma/general surgeons taking trauma call will be members. Other members include a representative liaison physician from anesthesia, emergency medicine, neurosurgery, orthopedics, internal medicine, and radiology. Other physician disciplines may be added as PI activities deem.

Non-physician members include administrative leadership and direct patient care staff from emergency department, critical care, orthopedics, neuroscience, blood bank/laboratory, radiology, pharmacy, and other disciplines as identified.

### **Responsibilities of members:**

1. Commitment to the trauma program.
2. Follow through with action items.
3. There is no term commitment.
4. Physicians shall adhere to the guidelines for attendance by the ACS and the State of Indiana.
  - a. Physician members shall attend at minimum 50% of the meetings.
  - b. Only one pre-determined alternate from the same specialty can be identified to attend the meeting in place of the liaison.
    - i. The total of the liaison and alternate's combined attendance must add up to 50% or greater. <sup>(1)</sup>
  - c. Meeting attendance may be waived for deployment, medical leave, and missionary work. Documentation to support absence must be provided. <sup>(1)</sup>
5. For issues requiring additional discussion or of potential impasse arises, committee may form smaller groups to address issues and bring back recommendations to larger committee.

### **Meeting Dates and Times**

Monthly meetings are scheduled on the Third Tuesday of every month. This date may be rescheduled pending holidays. Meeting requests will be sent out by Trauma Administration via Outlook.

## Criteria Deficiency Addressed

### 2014 Criteria <sup>(2)</sup>:

5-1	5-25	6-8
7-1	8-13	9-16
11-13	11-39	11-62
16-12	16-13	

Passed:

Original 10/15/2019

### References:

1. American College of Surgeons, & Verification Review Committee. (2019, August 16). Clarification document: Resources for optimal care of the injured patient. Retrieved September 9, 2019, from [https://www.facs.org/-/media/files/quality-programs/trauma/vrc-resources/clarification\\_document.ashx?la=en](https://www.facs.org/-/media/files/quality-programs/trauma/vrc-resources/clarification_document.ashx?la=en)
2. American College of Surgeons. (2014). *Resources for optimal care of the injured patient*. M. F. Rotondo, C. Cribari, & R. S. Smith (Eds.). Retrieved from <https://www.facs.org/-/media/files/quality-programs/trauma/vrc-resources/resources-for-optimal-care.ashx?la=en>

# Trauma Peer Review Committee

**Trauma Peer Morbidity and Mortality Committee:** The trauma program should have established committee membership and set meeting dates prior to application. This meeting must occur at least quarterly.

**a Documentation required:**

- i. Signed letter from Trauma Medical Director and Trauma Program Manager outlining committee membership and meeting frequency.
- ii. Complete Peer Attendance spreadsheet provided by ISDH Designation Subcommittee. Include data from most recent twelve (12) months.
- iii. All Trauma Surgeons and all the Liaisons must have attended at least two (2) Trauma Peer Review meetings prior to submission of the application, held no more frequently than monthly.

**Evidence:**

- i. Signed letter from TMD and TPM
- ii. Peer Review Attendance Spreadsheet

November 2019

The Trauma Patient Care Committee (Trauma PCC or TPCC) is scheduled monthly on the third Tuesday of the month. Meetings will occur quarterly at minimum.

Physician liaisons from the following areas participate on the committee:

- Trauma Medical Director
- Emergency Medicine
- Radiology
- Palliative Medicine (ad hoc)
- General/Trauma Surgery
- Critical Care/Internal Medicine
- Family Medicine (ad hoc)
- Anesthesia
- Neurosurgery
- Cardiovascular (ad hoc)

Administratively, support is provided by:

- Trauma Program Manager
- Quality Coordinator from Emergency Department/Critical Care
- Quality Coordinator from Surgical Services
- Trauma Services Administrative Assistant

  
Mark Edwards, MD, FACS, Trauma Medical Director

11/21/19  
Date

  
Christine Claborn, MSN, RN, CEN, TCRN, Trauma Program Manager

11-2019  
Date

## Franciscan Health Indianapolis Trauma Peer Review Attendance 2019

Total Number of Trauma Peer Review Committee meetings held :	3	*excused per ACS guidelines	1. Please place total number of Trauma peer Review Committee meetings held in B1 field 2. Place all meeting dates in columns starting in D2, using only the number of columns appropriate for your facility and deleting excess columns 3. Then list all committee members in column A with their attendance recorded in appropriate				
	Trauma Peer Review	Committee Member				Overall Attendance	Attendance Percentage
Specialty Represented	Last Name	First Name	10/15/2019	11/19/2019	12/17/2019		
Anesthesia	Henne	Shana			X	1	33%
	Terrall	Kurt	X	X		2	67%
Emergency Medicine	Hartman	Chris	X	X	X	3	100%
General Surgery	(TMD) Edwards	Mark	X	X	X	3	100%
	King	Don		X	X	2	67%
	Libke	Mathew		X	X	2	67%
	Mandelbaum	Jon			X	1	33%
	Murage	Karluki		X		1	33%
	Seudeal	Kyle		X	X	2	67%
	Wanko Mboumi	Igor		X	X	2	67%
	Internal Medicine/Hospitalist	Alawneh	Ahmad	X			1
Boone		Linda	X			1	33%
Internal Medicine/CCM	Snyder	Michael	X	X	X	3	100%
Neurosurgery	Spomar	Daniel			X	1	33%
Orthopedic Surgery	Laboe	Patrick		X	X	2	67%
Quality Coord IM & ED	Knight	Beth		X	X	2	67%
Quality Coord Surgery	Hentz	Debby	X	X	X	3	100%
Radiology	Paluszny	Mark	X	X	X	3	100%
	Blahunka	James				0	0%
Trauma Program Manager	Claborn	Christy	X	X	X	3	100%
AD HOC Members							
Cardiothoracic and Vascular Surgery (AD HOC)	Parikshak	Manesh				0	0%
Family Practice	Reiser	Jason				0	0%
Palliative Medicine	Mandelbaum	David				0	0%
Vascular Surgery	Webb	Tom				0	0%

Per 3/9/16 ACS revision document, one pre-determined alternate will be acceptable to attend the peer review in place of the liaison. (pg 15)  
 \*excused per 11/9/16 ACS revision document, peer review meeting attendance may be waived for deployment, medical leave, and missionary work. The center must provide documentation to support the absence.

# Nurse Credentialing Requirements

**Nurse credentialing requirements:** Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department and ICU.

a. **Documentation required:**

- i. Policy/guideline that outlines credentialing requirements for nurses in the ED and ICU.
- ii. Percentage of nurses that have completed credentialing requirements for both ED and ICU.

**Evidence:**

- i. Plan for the Provision of Patient Care
  - a. Emergency Department
  - b. Intensive Care Unit
- ii. Percent of nurses completing credentialing requirements – based off of Level III PRQ
  - a. Emergency Department
  - b. Intensive Care Unit

**Franciscan St. Francis Health  
Plan for the Provision of Patient Care**

**Department/Unit Name**

Emergency Department Indianapolis

**Campus**

Indianapolis

**Manager & Director Name**

Nurse Manager: Debi Schuessler, RN, BSN

Nurse Manager: Brad Fowler, RN, MSN

Director: Vince Corbin, MBA, RN, NE-BC

**Scope of Care and Services Provided**

Each clinical area will have a defined scope of care documented that includes:

- Type and ages of patients;
- Type of services most frequently provided (such as procedures, services)
- Hours of operation and method to insure services are available and accessible to meet patient needs
- This department serves patients of all ages from neonate to geriatric
- The department serves to identify or rule out life threatening emergencies, to treat and disposition patients to home or refer to a continuum of care.

**Staffing Mix**

Type and mix of staff required to provide services

RN's The department follows the ENA staffing guidelines which consider, volume, length of stay and acuity to determine appropriate RN staffing levels. Staff, including ED Tech's and HUC's, are adjusted by skill levels to meet volume and patient needs according to trending over time.

**Credentials and Competency of Staff**

Skill levels and scope of practice of personnel delivering services

Physicians are board certified or board eligible emergency physicians  
RN's have specialized orientation in emergency nursing and are required to be ACLS and PALS certified within 1 year of hire.

**Staffing Plans**

Staffing plans for patient care services are developed based on the level and scope of care provided and a determination of the skill mix and competency level of personnel that can most appropriately meet the needs of the patient.

Each clinical area has a formalized staffing plan that is reviewed annually taking into consideration the following: employee turnover, historical trends, benchmarking information, changes in the delivery of care model, changes in the standards of practice, performance assessment, performance improvement activities, patient satisfaction surveys, and changes in the customer needs/expectations. Staffing is adjusted from the base numbers below to meet the productivity metric of 2.81 hours per patient visit.

	7-11a	11-3	3-7	7-11	11-3	3-7a
RN	16	21	23	23	19	12
ED Tech	1	1	1	1	1	1
HUC	1	1	1	1	1	1

2018-2019

1

**Franciscan St. Francis Health  
Plan for the Provision of Patient Care  
2019-2020**

**Department/Unit Name**

**Adult Intensive Care Unit (AICU)**

**Campus**

**Indianapolis**

**Manager & Director Name**

**Karen Hunt, MSN, RN, CCRN, Manager, Cheryl Lynn Wolverton, PhD, RN, CCRN, Director**

**Scope of Care and Services Provided**

The 30 bed Adult Intensive Care Unit (AICU) provides 24 hour /7 day a week care for our acutely ill patients. The top 5 primary Diagnoses are:

1. Sepsis – (Multisystem Organ Failure)
2. Acute Respiratory Failure - (Acute Respiratory Distress, Pneumonia, Pulmonary Edema)
3. Overdose – (Poisonings, ETOH toxicity, unintentional and intentional overdose, suicide)
4. Mechanic Ventilator - (Chronic vents & trachs)
5. General – (Acute Renal Failure, ETOH toxicity, GI, neurosurgical)

The patients require 16.9 total productive hours of care per day. The staff mix is an all Registered Nurses (RN) staff with the support of Health Unit Coordinators (HUCs), and Patient Care Assistant/Patient Care Novice (PCA/PCN).

**Adult Intensive Care Unit (AICU)**

The Intensive Care Unit provides services that include both advanced monitoring and intensive treatment for the critically ill medical or surgical patient. The critically ill patients include those who require hemodynamic, neurological and physiologic monitoring or intensive treatments such as ventilator support, continuous vasoactive drug infusions, CRRT, or bedside tracheostomy. Examples of such patients may include those with:

- shock and related disorders
- multiple system organ failure
- pulmonary diagnoses including acute respiratory distress syndrome (ARDS), pneumonia and other respiratory infections, pulmonary embolism and respiratory failure
- renal problems including acute/chronic renal failure and acid-base disturbances
- critical neurological disorders including encephalopathy, complex or prolonged seizures, head injury or post-operative support-gastrointestinal emergencies including acute upper and lower GI bleeding or pancreatitis
- hepatic diagnoses such as liver failure
- endocrine diagnoses including ketoacidosis, hyperosmolar state or thyrotoxicosis
- infectious diseases
- management of acute ingestion of drugs and household poisonings
- behavioral disorders such ETOH abuse, suicidal attempt/ideations, mismanagement of psychotic medications
- unstable surgery patients requiring post-operative monitoring
- critical trauma

### Staffing Mix

The AICU utilizes an all RN staff model of care. To support this staff are HUCs, and PCA/PCNs. The Director of Critical Care Services administratively oversees the AICU and the manager is responsible for the operations of the unit and personnel. The AICU leadership team includes the director, manager, patient care coordinators (PCCs), clinical nurse specialist, Unit Clinical Expert, and nurse educator.

### Credentials and Competency of Staff

The basic requirements for RNs include:

- Current IN state licensure
- Current CPR certification
- Current ACLS certification within six months of employment
- Completion of critical care orientation

The basic requirements for PCA/PCNs include:

- Current enrollment in a school of nursing with one semester of clinical experience (acute care experience) for PCN
- Current CPR certification
- Completion of orientation
- Completion of CNA certification by the Indiana Department of Health or successfully complete the organizations training program specific to their job role for PCA

Specialized competency (core group of staff trained) of RN staff:

- Continuous Renal Replacement Therapy (CRRT)
- Neuro Critical Care
- Rapid Response Team RN (RRT)

### Staffing Plans

The AICU utilizes the following personnel to provide care to meet the needs of their patients: RNs, and PCA/PCNs.

Staffing guidelines for productive hours per patient day are established based on current industry standards. Staffing is adjusted based on patient acuity, census, staffing skill and mix and the number of discharges and transfers (ADT churn). AICU maintains a 2:1 staffing ratio with a change to 1:1 when acuity dictates. Ratio will be adjusted based on acuity of patients (i.e. Med/surg, progressive level of care).

Staffing variances are resolved utilizing the following resources as applicable:

Staffing shortages:

- Staff from other critical care units (SICU, CCU, MPCU, SPCU, CPCU).
- Med-Surg nurses may float to AICU to care for lower acuity patients under the supervision of a critical care nurse
- PRN or other off-duty personnel from the AICU
- Nursing Resource Center Staff (NRC) -Critical Care or Med/Surg in-house registry

Staffing overages:

- Cancel in-house registry
- Cancel overtime
- Float staff to another unit needing staff with applicable competencies

- Implement Hospital Convenience Time

In situations where patient needs or staffing concerns arise, the AICU leadership will work with the medical director and other units within the hospital to assure safe care delivery.

The following is the distribution of personnel by skill level and shift:

- % RN Care/Shift
  - D 100%
  - E 100%
  - N 100%
- HUC, PCA/PCN – variable, goal HUC 24/7, and PCA/PCN as needed

#### **Performance Improvement Plan**

Quality dashboard goals and indicators

1. CLABSI/CAUTI
2. SAT & SBT
3. Restraints
4. Purposeful Rounding

Revised 1/23/2019 KDH

### Nurse Credentialing Percentage – Emergency Department

Staff nurses complete modules by the Emergency Nurses Association during orientation process. These modules include the following trauma topics:

1. Abdominal and Genitourinary Trauma
2. Burns
3. Child and Elder Maltreatment and Intimate Partner Violence
4. Disaster Preparedness
5. Head Trauma
6. Maxillofacial Trauma
7. Musculoskeletal and Neurovascular Trauma
8. Obstetric Trauma
9. Spinal Trauma
10. Thoracic Trauma

### Percent who have completed nursing education:

1. ATCN: 0%
2. ENPC: 4%
3. TNCC: 47%
4. PALS: 100%
5. ACLS: 100%
6. TCAR: 1%
7. Other:
  - a. CATN: 13%

### Extra certifications for ED nursing staff (percent):

1. CCRN: 1%
2. CEN: 4%
3. PCEN: 0%
4. CNOR: 0%
5. CPAN: 0%
6. Other: 0%



---

Deb Schuessler, RN  
ED Clinical Manager

### Nurse Credentialing Percentage - Adult Intensive Care Unit

Staff nurses complete the Essentials of Critical Care Orientation from the American Association of Critical Care Nurses modules during the onboard process. These modules cover trauma topics including, but not limited to:

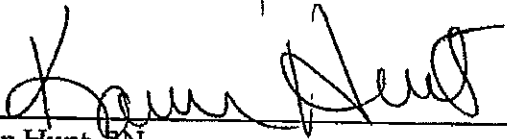
1. Cardiac and aortic
2. Pneumothorax/hemothorax/respiratory
3. Traumatic brain and spinal cord injuries
4. Abdominal trauma
5. Shock states

### Percent who have completed nursing education:

1. ATCN: 0%
2. ENPC: 1%
3. TNCC: 0%
4. PALS: 0%
5. ACLS: 90%
6. TCAR: 0%
7. Other: 0%

### Extra certifications for AICU nursing staff (percent):

1. CCRN: 15%
2. CEN: 0%
3. PCEN: 0%
4. CNOR: 0%
5. CPAN: 0%
6. Other: 0%

  
\_\_\_\_\_  
Karen Hunt, RN  
AICU Manager

# Commitment by Governing Body and Medical Staff

**Commitment by the governing body and medical staff:** There must be separate written commitments by the hospital's governing body and medical staff to establish a Level III Trauma Center and to pursue verification by the American College of Surgeons within one (1) year of this application and to achieve ACS verification within two (2) years of the granting of "in the process" status. Further, the documentation provided must include recognition by the hospital that if it does not pursue verification within one (1) year of this application and/or does not achieve ACS verification within two (2) years of the granting of "in the process" status that the hospital's "in the process" status will immediately be revoked, become null and void and have no effect whatsoever.

a. **Documentation required:**

- i. Written statement as outlined under requirements that is signed by governing body and medical staff representative.

Evidence:

- i. Written statement signed by Board of Directors
- ii. Written statement signed by Medical Staff

November 19, 2019

**Commitment of the Governing Body**

Franciscan Health Indianapolis' Governing Body is committed to becoming an established Level III Trauma Center and to pursue verification by the American College of Surgeons (ACS) within one (1) year of submitting the "In the ACS verification process" application and to achieve ACS verification within two (2) years of the granting of "In progress ACS verification process" status. If Franciscan Health Indianapolis does not pursue verification within one (1) year of the application and/or does not achieve ACS verification within two (2) years of the granting of the "in the process" status, the hospital's "in the process" status will immediately be revoked, become null and void and have no effect whatsoever.

Resolved, that the Franciscan Health Central Indiana Board of Directors approves the establishment of a Level III Trauma Center. The Board commits to maintain the high standards needed to provide optimal care of all trauma patients. The multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions.

  
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Wayne Schmidt  
Chairman, Central Indiana Board of Directors  
Franciscan Health Central Indiana Division

11/19/2019  
\_\_\_\_\_  
Date

INDIANAPOLIS  
8111 South Emerson Avenue  
Indianapolis, IN 46327

MOORESVILLE  
1201 Hadley Road  
Mooreville, IN 46158

CARMEL  
12100 N. Meridian Street  
Carmel, IN 46032


August 16, 2018

### Commitment of the Medical Staff

Franciscan Health Indianapolis Medical Executive Committee supports the Hospital's pursuit of American College of Surgeons' (ACS) Level III Trauma status within one (1) year of submitting the "In the ACS verification process" application and to achieve ACS verification within two (2) years of the granting of the "In the ACS verification process" status.

Further, Franciscan Health Indianapolis recognizes that if verification is not pursued within one (1) year of the application and/or does not achieve ACS verification within two (2) years of the granting of the "In the ACS verification process" status that the hospital's "In the ACS verification process" status will immediately be revoked, become null and void and have no effect whatsoever.

This statement acknowledges the commitment to provide specialty care as required to support optimal care of trauma patients. The multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions.

  
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Michael H. Brown, MD  
Medical Staff President (2017-2018)  
Chairman, Medical Executive Committee

8-20-18

Date